

Nashua Region (3) IDN Project Plan
October 31, 2016

Section I: IDN-level Plan

1. IDN Vision Statement and Theory of Action

Citing urgency in need, and in response to the initiatives contemplated by the New Hampshire 1115 Waiver, a broad range of health care providers, public entities and social service agencies who serve the Greater Nashua area gathered in March of this year to contemplate the opportunity to transform the health care delivery system for mental illness and substance use disorder for patients and for individuals at risk for these diseases. Together, IDN members are committed to ensuring a patient's right to self-determination, to living in the least restrictive environment as their health will allow, and to providing him or her supports that will promote optimal physical and mental health and well-being.

Since that time, members have focused on aligning support around the goals of the Nashua Region IDN. There is consensus that the Waiver, along with expanded Medicaid, will be the impetus for new ways to deliver behavioral health care and be an important tool in the fight against opioid addiction and its devastating effects on the patient, family and friends, and the community-at-large. In order to promote internal and external recognition of the intent of the Nashua Region IDN, member entities agreed on the following foundational statements:

Nashua Region IDN Vision Statement:

Working collaboratively, members of the Nashua Region Integrated Delivery Network (IDN) will achieve demonstrable results in greater behavioral health capacity, improved integration of physical and behavioral health, improved care transitions, and improved outcomes on behalf of the communities we serve.

Nashua Region IDN Mission Statement:

Members of the Nashua Region IDN will partner to design and implement projects to build behavioral health (mental health and substance use disorder) capacity, to promote integration of primary care and behavioral health, to facilitate smooth transitions in care, and to prepare for alternative payment models for Medicaid beneficiaries in a fashion that will ensure sustainability of the model.

Using these foundational documents as a guide, member entities of the Nashua Region IDN are committed to addressing gaps in care through carefully selected projects and initiatives designed to achieve measurable progress towards improving the quality of care and the care continuum for the target population. Such progress will be gauged by tracking and analysis of key metrics. These will cover a range of topics and consist of both process and outcome metrics. For example, in support of integrated care, tracking will occur for consistent application of evidence-based tools for mental health assessment and for access to care for vulnerable patients (who are homeless, living in poverty, incarcerated, elderly, or otherwise limited in mobility). Likewise, outcome measures will track efforts to

decrease the number of patients admitted to the ED because of lack of coordinated behavioral health care; a concomitant reduction in admissions and readmissions will be sought through IDN related programming.

2. IDN Service Area Community Needs Assessment

2a. Analysis of IDN Service Region Prevalence Rates

According to the October 2014 Community Needs Assessment (CNA) published by the Public Health Department, mental health and SUD are among the top 3 health concerns of the community. The legitimacy of those concerns are highlighted by the grid below that demonstrates the *prevalence* rates of mental health and substance misuse/substance use disorder (SM/SUD) in the target population contemplated by the New Hampshire 1115 Waiver. Although greater Nashua had no SM/SUD identified in children under the age of 12, the 10% prevalence of mental illness in this group is concerning. Even more remarkable are the statistics in adolescent youth. Although the numbers with SM/SUD or co-occurring illness are low, more than 30% of this age group in the target population was identified as facing the challenge of a behavioral health disorder. While the rates for seniors may be skewed due to a lack of Medicare statistics, the overall prevalence of these disorders presents a challenge. Most disconcerting is the prevalence of those adults with co-occurring illnesses. Although the absolute numbers represent just a fraction of those with behavioral health conditions, the intensity of services required to provide quality, integrated care across the continuum of care is essential to creating an environment in which they can maximize their physical and mental well-being.

Disease Prevalence Data Spreadsheet* Mental Health Conditions by Age Group Nashua Region IDN Attributed Lives

Age	Serious Emotional Disturbance	Serious Mental Illness	Substance Misuse (SM)	Substance Use Disorder (SUD)	Co-occurring mental health and SM condition	Co-occurring mental health and SUD condition	Mild-to-moderate mental illness (e.g. anxiety, depression)	No evidence of Behavioral Health Condition
Child 0-11	239/8,335 2.86%	–	–	–	–	–	860/8,335 10.31%	7,231/8,335 86.75%
Youth 12-17	281/3,799 7.39%	–	6/3,799 0.15%	5/3,799 0.13%	6/3,799 0.15%	–	888/3,799 30.64%	2,613/3,799 68.78%
Adult 18-64	36/11,357 0.31%	475/11,357 4.18%	71/11,357 0.62%	426/11,357 3.75%	87/11,357 0.76%	476/11,357 4.19%	3,480/11,357 30.64%	6,306/11,357 55.52%
Senior 65+	–	21/1,094 1.91%	–	–	–	–	255/1,094 23.30%	818/1,094 74.77%

* IDN 3 Data Book – Release 5, activity sheet 1.4, “Age group by Gender by Detailed BH Breakout, SED & SMI breakout and additional age group brackets added”.

The burden of mental health and SM/SUD in the Greater Nashua Region is a tremendous challenge given that many barriers exist to treatment access for these conditions. Despite many resources in the community (an accounting of services provided by IDN members appears elsewhere in this Project Plan) the mental health and substance abuse crisis, particularly as it relates to the opioid epidemic, has hit NH hard. The highly publicized death toll for overdoses is a symptom of this problem, but that statistic represents only a fraction of the number of children, adults and families impacted by this issue. Community conversations, a youth risk survey conducted by the Nashua Prevention Coalition (NPC) and elements of the CNA all point to the need for increased awareness and prevention, but much work remains to be done to ensure a sufficient work force of mental health professionals, access to timely and convenient appointments, an adequate number of treatment beds, bona fide integrated care, reliable care coordination. Significant work will still need to be done to reduce the stigma of seeking treatment and living with these conditions.

According to the October 2014 CNA, residents of greater Nashua also suffer from serious physical illnesses. The top leading causes of death in the GNPHR are cancer, heart disease, chronic respiratory disease, and cerebrovascular disease. These are especially prevalent in the local Medicaid population due to many factors, including obesity. The table that appears below summarizes the rates of various chronic diseases in patients with behavioral health conditions. Every age group is significantly affected, especially by respiratory conditions, which show the highest prevalence rates in each respective age group.

Physical Health Conditions Co-Morbid With Behavioral Health Conditions by Age Group*

Age	Cardiovascular	Respiratory	Diabetes	Cancer	Other
Child 0-11	56/8,335 0.67%	503/8,335 6.03%	5/8,335 0.05%	4/8,335 0.04%	990/8,335 11.87%
Youth 12-17	72/3,810 1.88%	459/3,810 12.04%	16/3,810 0.41%	4/3,810 0.10%	1,064/3,810 27.92%
Adult 18-64	1,340/11,369 11.79%	1,878/11,369 16.52%	461/11,369 4.05%	239/11,369 2.10%	4,475/11,369 39.36%
Senior 65+	194/1,105 2.98%	198/1,105 17.91%	90/1,105 8.14%	33/1,105 2.98%	277/1,105 25.06%

* IDN 3 Data Book – Release 2, activity sheet 1.5, “Age Group by Gender by Physical Health Conditions by Evidence of Behavioral Health Condition”

In contrast to capacity in the behavioral health space, service availability for primary care is strong in the GNPHR. Three large multispecialty practices have strong primary care components: Foundation Medical Partners, part of Southern New Hampshire Health (SNHH); St. Joseph Healthcare Physician Practices, and Dartmouth Hitchcock. In addition, Lamprey Health, a Federally Qualified Health Center (FQHC), hosts an active primary care practice, and integrated health care is also available at Harbor Homes (Partnership for Healthy Living, also an FQHC) and Greater Nashua Mental Health Center, a Certified Community Mental Health Center (CMHC). All primary care practitioners (PCPs) at these entities are accepting Medicaid patients. Likewise, the provider population in the Greater Nashua Region is highly

skilled and generally capable of handling chronic diseases. Their work is supplemented by a broad range of specialists available to consult on the most complex cases of physical illness.

Nonetheless, much work needs to be done to meet the needs of the target population, especially those with co-occurring illness. While the importance of integrating physical and behavioral health care services are widely accepted as best practice in the Nashua region, an internal assessment shows that opportunities exist to strengthen and deepen those services. Examples of integrated SUD treatment needs are: care coordination for patients with complex medical and SUD needs, nutritional counseling to reduce cravings, chronic pain management, and physicians/APRNs that can prescribe and manage patients on medication assisted therapy. In addition, most specialty practices are not designed to provide appropriate environments and sufficient resources to care for the most ill in these categories. Workforce issues will continue to hamper these efforts.

2b: Regional Demographics

The following statistics reflect the most recent available for the Greater Nashua Public Health Region.

City or Town	Population (2010)	Median Age (2010)	Unemployment Rate (2015)	Individuals Below Poverty Level (2010)
Amherst	11,201	44.6	4.0%	2.7%
Brookline	4,991	41.7	3.8%	0.8%
Hollis	7,684	47.2	4.2%	1.7%
Hudson	24,467	40.5	5.2%	4.4%
Litchfield	8,271	38.1	4.9%	4.7%
Lyndeborough	1,683	46.3	4.0%	5.5%
Mason	1,382	43.2	4.8%	17.7%
Merrimack	25,494	42.5	4.0%	3.8%
Milford	15,115	40.7	4.0%	6.0%
Mont Vernon	2,409	44.0	3.6%	8.2%
Nashua	86,494	38.3	5.1%	10.7%
Pelham	12,897	41.2	6.0%	6.2%
Wilton	3,677	43.8	4.0%	4.6%
Hillsborough County	400,721	39.9	4.5%	8.6%
State of New Hampshire	1,316,470	41.8	5.1%	8.9%

This table demonstrates a number of important themes that the member entities of the Nashua Region IDN must consider in developing their project plans. First, is the issue of poverty. While Nashua, by virtue of its size, has the most significant number of individuals living below the poverty level, the rates of poverty in towns like Mason and Mont Vernon should inform the process. In other towns like Pelham, where the unemployment is higher than the state average, consideration must be given to the fact that mental illness is a barrier to successful and sustained employment.

Patients who live in poverty and/or who may also be homeless can be especially difficult to manage from both a diagnostic and therapeutic challenge. Communication with such patients who often lack telephones is difficult, drug-free supportive housing is scarce, and access to care for people with limited mobility is a challenge.

There is also the issue of geography. The region is sprawling in nature; therefore, residents are largely car dependent. It is therefore problematic that the City of Nashua is the only community in the GNPHR with a fixed route transit service; an additional eight towns have a very limited on-demand response van service. Transportation challenges represent a significant barrier to obtaining health care services for residents without access to vehicles. For those with disabilities or with limited mobility, transportation needs become an even more significant problem; 29% of consumers who completed the IDN survey described below self-identified as disabled.

2c: Current resources available

The following table represents a high level view of the current mental health and SUD resources available to individuals in the greater Nashua area; additional details are threaded throughout this Project Plan and in the Network Composition Tab of this proposal.

Organization	Component Programs
Ambulance Services	Paramedics and transportation
Dartmouth Hitchcock Nashua	PCP and specialty physician practices
Foundation Medical Partners	Primary care and specialty physician practices with more than 300 providers Integrated Care in Primary Care Practices (PCPs) Psychiatric Consultation for PCP and specialty practices
Greater Nashua Mental Health Center	Certified Community Mental Health Center (CMHC)
Lamprey Health Care	Federally Qualified Health Center (FQHC)
Multiple Psychiatric Facilities	Hampstead, Concord, Portsmouth, Parkland, Cypress Center
Nashua Court System	Drug Court and other legal proceedings
Nashua Fire Department	Paramedics
Nashua Police Department	Law enforcement; safety and security at the SNHMC ED
New Hampshire Hospital	State-run psychiatric hospital
NH Partnership for Successful Living	Federally Qualified Health Center (FQHC) Parent company of six member organizations including a primary housing entity supported by several Housing and Urban Development (HUD) grants, as well as Keystone Hall, a substance abuse recovery program
Public School Districts	Nashua and surrounding communities
St. Joseph Hospital	Community hospital in Nashua with affiliated PCP and specialty physician practices. Utilizes

	Telehealth for consultative Behavioral Health services for our ED and inpatient settings.
Southern NH Medical Center	Emergency Department, Behavioral Health Unit, Substance Misuse Intensive Outpatient Program, Partial Hospital Program

Many recent activities in the Greater Nashua Area hosted by these IDN member entities are designed to increase awareness and promote early intervention for mental health and SUD diagnosis and treatment. The goal is to connect the patient to appropriate care at a stage of their illness that requires less intensive intervention, thereby freeing up staff (and resources) to treat more patients. However, there remain insufficient services to meet the current need. The result is long waiting lists for services that should be available when the patient seeks assistance - at the stage of change that supports engagement in treatment. Longer wait times at area hospitals for patients waiting to be admitted to inpatient treatment facilities has also occurred despite meaningful attempts at increasing capacity.

In response to these factors, SNHH has opened 40% more inpatient beds and extended their Partial Hospitalization Program (PHP) to 7 days per week to accommodate patients requiring a higher level of intensity; Harbor Homes has also added capacity with a new PHP. Both SNHH and Harbor homes opened Intensive Outpatient Program (IOP) for SUD, and Harbor Homes recently received a grant to expand their programs and to support Medication Assisted Therapy. GNMHC has recently been successful in longstanding attempts to recruit adult and child psychiatrists, along with additional mental health professionals.

On October 24th, a dedication took place for the new Peggy and David Gilmour Medical Respite Center, which is anticipated to open in the coming weeks. The Medical Respite Center is physically co-located in Harbor Homes' existing federally qualified Harbor Care Health and Wellness Center in Nashua. The Medical Respite Center is the state's first and only interim medical program of its kind and will host 13 beds providing 24 hour, 7 day per week preparation and recuperation attention (including behavioral and substance misuse) to bridge the gap and fill the void in the delivery of health care services for our underserved population, including our veterans.

The concern with all of these programs is long term sustainability due to a lack of stable funding and a lack of qualified work force. Member entities look to the opportunities presented by the NH 1115 Waiver and to each other to bridge this gap.

As for the one of the main social determinants of health, St. Joseph Hospital and the City of Nashua Division of Public Health and Community Services are partnering to fund a mobile health clinic. The \$350,000 clinic will offer extended hours of service to the 13 Nashua Region IDN communities. The new vehicle is a vast improvement from the obsolete mobile health clinic because it features a private space for a primary care provider to perform physical exams and treat urgent conditions. The new vehicle will provide screenings, counseling, and access to management for chronic diseases including mental health issues as well as lead poisoning, high blood pressure, diabetes, hepatitis, and HIV. Vaccinations for all major childhood and adult illness will also be made available. Future plans also include dental care to thousands of area residents who currently struggle to see a dentist.

2d: Assessment of gaps in care:

In order to assess gaps in the Greater Nashua Area, across age groups, across disease states and across the geographic region that makes up the IDN, member entities and the committees in which they participate examined data provided by the state and information gathered from the hundreds of community leaders, providers, consumers and caregivers that completed targeted surveys. Consideration was given to gaps across the continuum of care, including detection, diagnosis, treatment, management, and recovery. On a high level, these gaps in care cover several key themes, including

- Insufficient services to meet current need, including the ability to respond to those seeking treatment for mental illness and SUD evenings and weekends.
- Lack of qualified, skilled professionals to expand capacity
- Lack of care integration and coordination
- Lack of stable funding, which inhibits programmatic development
- Lack of an SUD benefit in the prior structure of the Medicaid program has left many with the perception that there is no help
- Lack of resources to address social determinants of health that contribute to an inability to comply with and maintain treatment regimens
- Lack of prevention and early intervention

Information that informs this list comes from the community assessment surveys that were distributed over a several month period. There was a robust response from leadership and providers, with geographic distribution throughout all 13 towns covered by the IDN, and there was a considerable response from caregivers. However, consumer surveys were underrepresented, and key groups were under-represented, including the immigrant community, ESL community, and several outlying towns (Hollis, Lyndeborough, Mason, Mont Vernon, Pelham, Wilton).

Surveys indicated a significant lack of access to timely care in all domains of care, from individual counseling to group to wraparound support services. A table appears below in section 6 of this document. This sentiment was echoed in both the consumer and caregiver surveys. It was acknowledged that Workforce issues are a significant barrier to access. Nonetheless, less than 10% of leaders and providers felt these services were available when needed:

- Mental health/ SUD services in jails
- Inpatient Psychiatric Rx
- Withdrawal management/detox
- Supportive living/housing
- Residential Rx
- Sober living/transitional housing
- Respite services
- MAT

Priority populations identified included child/adolescent services, homeless and veteran's services, elderly services and services for those with co-occurring disorders. A general theme was assistance for those at risk for getting lost in transitions of care.

Surprising themes included:

- The lack of understanding/knowledge amongst leaders of services that are available and who/where to ask.
- The proportion of those battling SUD who expressed that they were not ready to pursue treatment (expressed by consumers and caregivers).
- The number of people who rated their health as good, very good or excellent (65%) raising questions about the reach of the survey to more vulnerable populations, although 29% of consumer respondents identified themselves as disabled and 50% of consumer respondents were covered by Medicaid.
- The number of patients with mental illness who thought they could “handle it on their own” (45%)

Comments were also reviewed as follows:

- *What should be done to improve mental health and SUD services in your community? (consumers)*
 - 44% commented on limited availability
 - 31% commented on the need for more dignity and less stigma through education and awareness.
 - 20% wanted more options for Rx
 - 9% were seeking increased peer support
- *Where should efforts and resources be focused to improve the behavioral health care system and related outcomes in your community? (providers/leaders)*
 - Improved communication/integration of services.
 - Better access to providers
 - Payment reform/ improved reimbursement
 - More training
 - Removing stigma
 - Early intervention

3. Community Engagement and Stakeholder Input (20 points)

3a: Narrative description of IDN solicitation of community input in developing project plan:

To successfully introduce innovation and change, all groups and individuals who need to own new procedures must be involved in the process of developing new ways of doing business. Toward that end, community engagement for the work of the Nashua Region IDN was transparent, and outreach, discussion, and consensus were cultivated through meetings, consultations, focus groups, surveys, and writing and editing teams that involved executive officials and other professionals from the health care field, leaders in local health care organizations and social service organizations, local community leaders, and city and town officials.

Rich channels of communication were utilized throughout the development of the Nashua Region Project Plan, including general announcements through multiple electronic means, facilitated face-to-face meetings, sharing of written meeting notes with meeting attendees and organizational leaders including members of the Mayor’s Opioid Task Force and the Nashua Prevention Coalition, sharing of business contact information among meeting attendees and organizational leaders, follow-up through personal and conference call phone calls, and exhaustive use of email communication. Venues and

meeting times varied to accommodate participants and to encourage attendance in order to solicit input to inform the process of Project Plan selection and development.

An initial informational meeting was held March 28, 2016, with more than 40 participants from Southern NH Medical Center, St. Joseph Hospital, Dartmouth Hitchcock of Nashua, City of Nashua Division of Public Health and Community Services, Greater Nashua Mental Health Center, multiple agencies of the Partnership for Successful Living (including Harbor Homes and Keystone Hall), the Nashua Prevention Coalition for reducing alcohol and substance abuse, Gateways Community Services serving the developmentally disabled, H.E.A.R.T.S. Peer Support Group, Gate House Sober Community, Lamprey Health Care (a federally qualified health center), Southern New Hampshire Services, The Youth Council, YMCA of Greater Nashua; the Honorable James Donchess, Mayor of the City of Nashua, also participated.

Subsequent follow up meetings with smaller groups were convened at different times of the day to encourage participation by the broadest range of invested individuals in a facilitated conversation about the needs of the community specific to the areas identified as part of the 1115 Waiver. Key leaders and members also spoke at various public forums.

To ensure transparency, notes from meeting were collated, organized, and widely distributed to attendees, and their superiors and colleagues from other community organizations that were unable to attend but wanted to be keep current with discussions and decision-making. Also shared were executive summaries of IDN work, bulleted summaries of key concepts and goals, and information formatted into PowerPoint presentations so that data and community input could be brought back to and easily shared with stakeholders in the respective member entities. Established rich lines of communication will continue throughout the Project Plan implementation.

The following three key elements for successful community engagement in the Nashua Region IDN were identified as a result of this transparent and inclusive outreach:

- The need to maintain transparency in developing and implementing community-driven plans among all stakeholders.
- The need to actively solicit input and feedback from all stakeholders, including consumers, leaders, educators, families, parents, and caregivers.
- The need to develop additional means of communication and gathering input.

In this regard, members of the Nashua Region IDN reviewed the contents of the most recent Community Health Assessment (CHA) and Community Health Improvement Plan (CHIP) published by the Nashua Division of Public Health and Community Services in 2014. While the CHA and the CHIP touch on many issues affecting the target population as it relates to access to services in general and to mental health and SUD care in particular, members of the Nashua Region IDN concluded that much more research, detail, and analysis were needed; consequently, Behavioral Health Needs Assessment surveys were identified and adapted by a collaborative effort of the members of the Nashua Region IDN Community Engagement Committee for use in the geographic area covered by this IDN. The surveys were both comprehensive in scope and inclusive of verbiage meant to educate recipients about the IDN member entities, their goals, the ways in which the information gathered through the surveys would be used and the value of this type of individual input. In recognition of the Nashua Region IDN governance

infrastructure, the members of the Executive Committee endorsed the final survey content and the following distribution plan:

Distribution Plan for Nashua Region Community Surveys:

- Providers' and Leaders' surveys were sent for completion electronically.
- Consumer and Caregiver surveys were sent for completion electronically and were optionally available in paper format.
- Agencies were asked to distribute to their providers, consumers, and caregivers, electronically where possible and in paper format when more expedient.
- Letters and emails used to introduce the surveys and promote completion included scripting to educate people that they may get duplicate requests, but should only complete one.
- Agencies were encouraged to provide assistance for consumers unable to complete the survey due to language or literacy barriers and until translated versions compliant with the language specifications of the DRSIP could be created.
- The medical leadership of member entities, including the 3 large multispecialty groups described elsewhere in this report, distributed provider surveys.
- Leadership Survey distribution included all 13 Towns in the Nashua Region, and were targeted to the following groups:
 - All IDN member entities
 - EMS
 - Fire Chiefs
 - Police Chiefs
 - Superintendents
 - Principals
 - Public Defenders/Drug Court/Mental Health Court/Veteran's Court
 - Town Administrators
 - Religious Leaders
 - Welfare Offices/Public Health
 - Office for Public Guardians
 - CASA
 - Social Services Agencies
 - Soup Kitchen
 - Food Pantry
 - Housing
 - Other Partnership for Successful Living entities not already members of the IDN
 - One Greater Nashua

- Prevention Coalitions
- My Brother's Keeper

Collection and analysis were facilitated by the use of survey monkey, with paper surveys manually entered by staff of the Administrative Lead. Results were shared widely within the IDN at meetings and through electronic means. Results formed the basis for many and ongoing discussions to select, develop and refine Project Plans.

3b: Narrative description of IDN solicitation of community input during demonstration:

Community Engagement – Defining Key Elements of a Plan

As part of the process for soliciting community input described above, the members of the Community Engagement Governance Subcommittee of the Nashua Region IDN met to review the expectations of the NH 1115 Waiver relative to community engagement and to define key elements of a strategic plan that includes details of robust community engagement for the duration of the demonstration project. For this purpose, they considered the results of the community surveys described above as well as input from all IDN members who were asked the following question: "Please provide 2-3 suggestions of HOW you see the Community Engagement Committee actually bringing the IDN's work to the community and, in turn, bringing the community's feedback to the IDN to inform the process over the next 18 months?"

Initial discussions centered on how to achieve wider distribution of surveys and overall wider engagement, especially in light of the intent to utilize the future and ongoing Community Needs Assessment process, to both gather and distribute information and education to the community. Relative to the surveys, members endorsed a plan to use existing groups to reach beyond our present distribution. These include outreach to consumers and caregivers through GNMHC, H.E.A.R.T.S., shelters, the Interfaith Council and the faith communities they represent, the Nashua Soup Kitchen, Harbor Care, Public Health, Meals on Wheels, and Gateways. Members also encouraged the engagement of Patient & Family Services departments at major facilities (SJH, SNHMC, FMP, DH - Nashua) who often interact with the target populations. Additional distribution was felt possible to achieve by informing Legislators and Alderman of our efforts and by seeking permission to leave paper surveys where they can be widely accessed, such as at libraries, public health facilities, and employment security.

Next, members considered whether we had collectively identified and reached all intended input/stakeholders. They identified the following groups who were underrepresented in engagement work to date and who must form the basis for specific efforts at inclusion going forward:

- Hispanic/Latino
- Immigrants
- Deaf and hard of hearing
- Disabled (felt that the 29% self-identified in the CNA was too low)

- Missing towns, as described elsewhere in this report.
- Judges
- Drug Court
- Incarcerated
- Public Defenders

Members also discussed the importance of consistent messaging, which could reasonably be adjusted in level of sophistication or mode of communication according to the audience:

- IDN Members and provider communities
- Community agency stakeholders
- Consumers of mental health and SUD services
- Seniors - should not rely on electronics exclusively but rather should include newsletters, service links, Senior Center programming and social activities
- Baby boomers to be reached on Social media such as Facebook, LinkedIn, and through smartphone technology
- Gen Y, who rely on Instant messaging, text and email, and video
- Incarcerated and Drug Court attendees (Mental Health Court is already represented)

Discussion included a consideration of the most appropriate and effective channels and venues through which overall input would be solicited. In addition to recognizing the needs of the groups identified above, members communicated to the Executive Committee their intent to craft a robust plan based on the following:

- PSAs on radio, TV, public broadcasting, conventional media/press releases and social media platforms. Examples from NAMI and WSMN radio broadcasts on Friday mornings were cited as appropriate examples to build upon.
- Listening sessions with trained moderators of EXISTING groups/sessions, leveraging existing venues/groups:
 - Peer support groups
 - NAMI
 - Information sessions at:
 - Libraries
 - High schools/colleges
 - Hospitals
 - Chamber events

Members also recommended to the Finance and Executive Committees that funds be allocated for a Website that is publicly facing and in plain English to include information on:

- IDN activities
- Inventory of mental health and SUD services
- Electronic meeting updates specific to:
 - Consumers
 - Professionals

Another innovative and potentially valuable way of engaging the treatment and professional communities in supporting the work of the IDN was also submitted for consideration. Offering CME/CEU about the Project, referral systems, early signs of mental illness and SUD, how to craft a treatment plan, how to best accomplish trauma informed care (invisible wounds), and ethics were among the topics suggested by the members of the Committee for such activities. A collateral benefit and key motive in offering such events is to enhance their knowledge about and comfort level with treating mental illness and SUD. The following groups were identified

- Psychiatrists
- M-LADC
- Peer specialists
- Nurses

In addition to these provider groups, it was also suggested that teachers would benefit from these activities, as it pertains to their role in prevention, early detection and even in their role to help students struggling with mental illness and SUD to successfully participate in the treatment plans.

In designing and supporting such activities, Committee members anticipate reaching out to established groups and agencies working in the education domain. For example, the Area Health Education Center (AHEC) could be instrumental in helping to determine what is needed to supplement that which is already offered in the community. Likewise, the value of tapping in to the NAMI speaker's bureau and the "In my own Voice" program was discussed. There may also be opportunities to work with and complement the efforts of the "Change Direction NH" initiatives. In addition, members felt strongly that there was an opportunity to innovate in the development of these programs, using formats like case conferences, mock drug/mental health court, interdisciplinary panels and even a "Ted Talk" construct.

Finally, members discussed the frequency with which community input should be sought and how this will be sustained for the duration of the project. Key concepts include:

- Annual surveys
- Restarting the in-person/community gathering information cycle every 6 months to coincide with the submissions to DHHS of progress and milestones.
- Ongoing through electronic means above.

4. Network Composition (10 points)

4a. Finalized network list (IDN Project Plan Supplemental Data Workbook, 4A Tab

4b: Description of how IDN network will be leveraged to address care gaps:

The Nashua Region IDN was conceived to respond to the opportunities presented by the DSRIP program by leveraging the experience and good counsel of a broad range of providers, service agencies and public health personnel specifically in order to be able to build on the many ongoing initiatives currently in progress in the State of New Hampshire. Collectively, the member entities of the Nashua Region IDN are engaged in caring for the community through all of the programs as listed above.

Many inaugural activities of the Nashua Region IDN have been directed at ensuring that each member entity has a foundational knowledge of the work of other agencies/colleagues and to build relationships and trust between the member entities so that Project Plan choices are a response to the needs of the community and collectively build an enhanced system of care on behalf of those we serve. This includes broad discussions that involve all member entities, as well as more detailed discussions and exchange of ideas as takes place at and between meetings of the Clinical Governance Committee, the Financial Governance Committee and the Executive Steering Committee. In the Nashua Region, we are fortunate that the dedicated and committed leaders and clinicians within each member entity have made it a point to be involved in and to work together in the context of local, regional and state-wide initiatives that are not part of the aforementioned list but directly touch on building the systems and directing resources that will serve as foundational elements for the work of the IDN. These include, but are not limited to New Hampshire Health Information Organization (NHHIO), Wrap Around/Elder Wrap Care Coordination meetings, The Nashua Prevention Coalition, and Mayor Donchess' (Nashua) Opioid Task Force.

As relationships continue to grow and evolve within the Region and throughout the State, work will be ongoing to allocate resources among the members of the IDN network in order to most effectively and efficiently address care gaps, with the ultimate goal of actuating the Mission and Vision of the IDN and as outlined in the section above on Theory of Action.

Specifically, IDN network members will develop plans to narrow gaps in care by:

- Collaborating locally and throughout the state with DHHS, human resource and higher education officials to develop a campaign to expand the work force and to recruit and train skilled employees to expand access for patients.
- Sharing work force resources, whenever possible, to ensure the widest possible access to care across the IDN.
- Collaborating locally and throughout the state to develop the HIT that will be necessary for effective and efficient communication to enhance transitions in care and the continuum of care.

- Sharing experiences, to allow replication of successful initiatives across the IDN and to avoid repetition of unsuccessful initiatives, particularly as it relates to achieving a higher level of integration between mental and physical health care.
- Leveraging the time and knowledge of clinicians across the IDN to identify, adopt and operationalize evidence-based tools and consistent practices across the IDN to ensure a consistent level of care.
- Conducting more detailed inventories of available resources, their scope and their scale and collaborating to determine ways to reach out to those who are most vulnerable, specifically those who are homeless, living in poverty, incarcerated, elderly, or otherwise limited in their ability to access care.

Finally, by consensus, member entities understand that achieving the goals contemplated by the 1115 Waiver will also involve work by agencies and organizations that falls outside the scope of the specific IDN Projects. As such, attendees are regularly engaged in conversation about the need to leverage the work of the IDN within the context of strategic planning in their own agencies and organizations.

5. Relationship with Other Initiatives

Dialogue within the IDN, as well as with the broader community, has emphasized that work of the IDN must lead to deployment of new and innovative steps to redesign the delivery of behavioral health and SUD treatment or to significantly enhance existing programs.

The narrative that follows is a sampling of ongoing delivery system initiatives that involve IDN participants. The payment source (except where stated) is presently 100% Fee for Service, some of which does include payments for patients covered by traditional Medicaid or the NH Health Protection Program. Element of the Compliance Plan that appears elsewhere in this document will complement internal inventory work that will continue for the duration of the demonstration. The Plan commits member entities to a process of education, operations and monitoring that ensures compliance with the requirements of the Waiver and that prohibits using IDN funds for activities that are supported by federal funds.

In order to accomplish the aforementioned goals, more robust means of communication between agencies and health care organizations must be achieved. The NH Health Information Organization (NHHIO) is designed to facilitate the secure exchange of protected health information between providers. While NHHIO is not able to aggregate or store clinical information due to legislative constraints, it is capable of securely connecting healthcare communities for the sharing of health information needed for informed health care decisions. Since NHHIO connects directly with many electronic health record vendors and can provide web-based access or other network connections, it is poised to support care coordination, treatment, and quality assurance needs regardless of their technology in use.

Currently, NHHIO has more than 75 participating members across New Hampshire, including the following members of the Nashua Region IDN: Southern New Hampshire Medical Center, St. Joseph Hospital, Lamprey Healthcare, Greater Nashua Mental Health Center, Home Health and Hospice, and the

NH Department of Health and Human Services. In addition to collaboration through the state-designated provider of health exchange services (NHHIO), SNHH built interfaces to transmit key patient data to 2 potential IDN partners – Home Health and Hospice and Lamprey Healthcare.

Several members of the IDN have invested in integrated care treatment models. Greater Nashua Mental Health Center (GNMHC) provides clinical support to physicians in Dartmouth Hitchcock practices; the Partnership for Successful Living has on-site programs that provide medical care, psychiatric services and dental care; and Lamprey Healthcare has a history of successfully implementing integrated care through a federal grant. Keystone Hall, a member agency of the Partnership, has committed to providing integrated treatment for Substance Use Disorder. Foundation Medical Partners is currently building a system of embedding behavioral health providers in its Primary Care PCMH (Patient Centered Medical Home) certified practices. Likewise, efforts are ongoing to enhance care coordination for individuals and between key entities. SNHH, SJH, Lamprey and DH-N added care coordinators and met regularly to leverage capacity for both primary and specialty care, especially for the target population. Significant work remains to establish an efficient transition process when moving the patient - from one level of care to another, from one facility or organization to another or when care involves multiple providers along the continuum of care.

Over the last several years, key IDN members have worked to enhance capacity. SNHMC increased inpatient beds by 40% and opened an Intensive Outpatient Program. GNMHC and Harbor Homes also expanded programming, as described elsewhere in this document.

The Acute Community Crisis Evaluation Service System (ACCESS) at SNHMC provides 24 hour, year-round emergency evaluation services for patients who arrive at the Emergency Department (ED) experiencing an acute episode of an established or new psychiatric condition as part of their presentation. The ACCESS team evaluates all such patients, independent of the type or location of their primary behavioral health provider. Patients arrive from a broad geographic area that includes all towns in the Nashua Region IDN. The objective of the team is to identify the level of care needed to address both immediate issue(s) and short-term needs based on evidence based assessments. The goal is to ensure that each patient leaves the ED with a plan that is focused on safety and care coordination, whether they are discharged to be followed up in the community, enrolled in an intensive outpatient program, admitted to an inpatient setting or transferred to another facility. Work is ongoing to ensure that, as appropriate, patients are discharged back into the community, with a solid discharge plan to the next care provider and to community support personnel. The success of this program is due to collaboration with IDN member agencies.

Several IDN entities are active participants in the state's regional Public Health Networks. Leadership from Lamprey serves on the executive committee of and as the fiscal agent for, the Seacoast Public Health Network. As such, Lamprey receives state contract and foundation grant funding to support public health emergency preparedness, community health needs planning and substance use prevention and education.

Lamprey Health Care is among several entities that belong to Primary Health Care Partners, LLC, a Management Services Organization that presently has an agreement in place with NH Healthy Families. Cost savings are shared with participating MSO providers for the achievement of cost, quality and utilization improvement relative to established benchmarks. Likewise, Lamprey Healthcare receives

funding to support infrastructure and quality/data reporting through CHAN, the Community Health Access Network. Seven partner organizations share a common electronic medical record and practice management system platform and work collaboratively to collect, compile, analyze and report clinical, quality, cost and demographic data for the populations served (primarily uninsured and Medicaid).

GNMHC receives federal funding for several programs, including Projects for Assistance in Transition from Homelessness (PATH), the Supervised Visitation Center (SVC), Drug Court, and homelessness funding through HUD, but there is no funding of programs contemplated by the Project Plans in the Nashua Region IDN.

6. Impact on Opioid Crisis

As noted earlier, the opioid crisis has hit New Hampshire hard. In 2015, 439 residents died from a drug overdose. According to the New Hampshire Medical Examiner's Office, fentanyl continues to be the main culprit behind the deadly overdoses in New Hampshire and has been linked to 70% of drug deaths so far in 2016, where at least 286 people have fatally overdosed on opioids or other drugs. The Medical Examiner's Office cautioned that the actual number could be even higher because it takes several months to review and confirm each reported overdose death.

To increase treatment capacity takes time and manpower. In the interim and for the short term, timely access to opioid-related services is imperative to curtail the epidemic. Based on the gaps identified in the Community Needs Assessment, lack of access to care, lack of care coordination and lack of social supports to patients and families in order to comply with treatment and maintenance strategies are all contributing factors to the current opioid crisis. These barriers too often result in no care, delayed care, or duplicate care. Patients and caregivers are often confused as to where to seek help, and leaders and providers are often unaware of the resources available.

The following are key findings of the Nashua Region community needs assessment as it relates to SUD, and all IDN members have been given an opportunity to review these findings to inform their thinking about and contributions to this document and the Project Plans

Highlights of Consumer Survey

~22% of consumers experienced a time in the past 12 months when they did not receive services they needed for **SUD**:

- No openings (37%)
- Thought they could handle without Rx (41%)
- Didn't think needed (46%)
- Did not know where to go (23%)
- Not ready to stop using (46%)

Service Needed but not Received	Mental Health	SUD
Individual Counseling	39%	55%
Both Mental Health and SUD (co-occurring)	28%	55%
Recovery Support Services	23%	45%
PHP/IOP/Group Therapy	17%	40%
Medication/Prescription Management Assistance	28%	25%
Safe Housing	20%	20%
Peer Support Services	17%	35%

When Consumers were asked what should be done to improve mental health and SUD services in your community?...

- 44% commented on limited availability
- 31% commented on the need for more dignity and less stigma through education and awareness.
- 20% wanted more options for treatment
- 9% were seeking increased peer support

Highlights of Caregiver Survey

Caregivers indicated that 20% of the people they were caring for were not receiving needed care, but...

- 50% were not ready to stop
- 46% thought they could handle without therapy
- 39% didn't think they needed therapy
- 36% did not think the services would help

The types of care needed but not received included:

- 40% both mental health and SUD (Co-occurring)
- 28% Individual Rx/counseling
- 28% Hospital or residential Rx
- 20% family Rx or counselling
- 20% employment services
- 20% transitional housing
- 8 % Peer support services

Caregivers would tell another family/caregiver these ideas about what held them back or helped the most:

- 30% mentioned the importance to them of NAMI
- 28% sought better access to care and providers
- 28% expressed the need for caregiver support groups
- 15% cited ER wait times and subsequent wait for inpatient treatment beds as a problem

- Other themes:
 - The need for educational resources for help with understanding both mental health and SUD and for guidance in navigating healthcare system.
-

There were some very common yet surprising themes to the Provider/Leader Surveys, in both content and perceived scope of the problems. Specifically, they stated that there was...

- lack of capacity (84%/82%)
- insufficient workforce (75%/77%)
- limited/no insurance coverage (70%/61%)
- not knowing where to go (47% /63%)
- lack of communication between providers (42%/44%)
- Lack of coordination (42%/44%)

Furthermore, less than 10% of respondents felt these services were available when needed:

- Mental health/ SUD services in jails
- Inpatient Psychiatric Rx
- Withdrawal management/detox
- Supportive living/housing
- Residential Rx
- Sober living/transitional housing
- Respite services
- MAT

It is with this information in mind that Nashua Region IDN partners are committed to aligning program services and eliminating silos by making interagency cooperation and collaboration a priority. The planned work of the IDN to combat the opioid crisis, now and in the future, is threaded throughout this document. Interim priorities include addressing the need to increase the number of qualified, skilled professionals as well as care coordination. A comprehensive approach to educating consumers, caregivers, providers and leaders will also be needed to achieve these goals. This includes efforts to compliment local and statewide efforts on recognizing the signs of SUD, early prevention and intervention, reducing the stigma of drug addiction so that individuals will seek treatment and be amenable to attempts by those around them to refer them to help. Resources will also be directed to help stakeholders understand the need to develop a chronic care model to treating SUD patients, and then educating providers and leaders so that appropriate referrals to these programs can be made.

In order to achieve these goals, the Nashua Region IDN will build upon local and statewide programs. A description of local programs appears below, but where not already in process, these will be tied into statewide initiatives, including:

- Governor's Commission on Alcohol and Drug Abuse
- State Innovation Model (SIM)
- New SUD Benefit for Traditional Medicaid Population

At Harbor Homes, integration allows primary care providers to conduct a risk assessment on all new patients and to immediately bring patients who score high for SUD to the Keystone IOP. As described elsewhere in this Report, Harbor Homes has recently added an IOP and medical respite beds, and Southern New Hampshire Health has also made substantial investments in this population by adding an IOP and additional inpatient beds for those who are acutely ill. Likewise, investments in care integration for mental health within key primary care practices in the IDN and as threaded throughout this Report will foster treatment of mental illness so that individuals do not enter the cycle of self-medication that can lead to SUD.

Keeping patients engaged while they are on waiting lists for rehab and other SUD programs is a significant care transitions challenge. Further increasing capacity in IOP's is a longer-term goal; in the interim, they can benefit from an increase in support groups and step-down programs for patients on waiting lists.

Regarding the need for social supports, the Nashua region is a large area with a diverse demographic and diverse service needs, however, several themes are common to all. The challenges in transportation described above are compounded for patients with mental illness and SUD, due to their unique problems, and psychiatric home care for patients who are homebound due to illness is virtually unavailable. This will form the basis for more long term interventions.

Insufficient social supports multiply the challenges of caring for patients with mental illness and SUD. Homelessness complicates treatment exponentially. Homelessness prevention is a crucial goal for improving the health of greater Nashua residents. In addition to better access to mental health and SUD services, patients at risk for homelessness would benefit from increased Personal Support services, from an expedited time frame for approval for funding for community support services, greater access to emergency rent and fuel assistance, housing crisis intervention, and better community awareness of available resources.

The IDN also has the support of the Mayor's Opioid Task Force, which is comprised of dozens of community leaders, providers, people in recovery and concerned citizens. This group also offers access to self-help entities and other community supports. H.E.A.R.T.S. will bring the skills and compassion of peer support and family education to the IDN, as will the National Alliance on Mental Illness (NAMI). The court system, law enforcement, fire and rescue, and the public school system are all committed to supporting the IDN, even if not official IDN members. The purpose of the Task Force is to share information and perspective about the opioid crisis facing the Greater Nashua community and to create a broad and shared understanding about the contributing factors, the populations affected, the scope of the problem, the resources available, the resources needed, the barriers to care and the potential solutions to improve the health and well-being of our community. A secondary goal of the group is to build working relationships between community providers of health care (including mental health and substance use disorders) and social service agencies that will facilitate collaboration on key issues.

While the importance of integrating physical health and behavioral health care services is widely accepted as best practice in the Nashua region, opportunities exist to strengthen and deepen those services.

Examples of integrated SUD treatment needs are: care coordination for patients with complex medical

and SUD needs, nutritional counseling to reduce cravings, chronic pain management, and physicians/APRNs who can subscribe and manage patients on suboxone. It is imperative we expand capacity for Medication Assisted Treatment (MAT) in order to support patients working towards long term recovery. Workforce issues will continue to hamper these efforts.

7. IDN Governance (50 points)

7a: Overall governance structure:

As stewards of the Nashua Region IDN, the Administrative Lead management team will focus efforts on working collaboratively with the diverse member entities to achieve the vision and mission of the Project Plan, leading efforts to ensure integrity, clarity of purpose, accountability, and effectiveness of the Plan. The governance structure adheres to established principles: participatory, accountable, and flexible, as defined by the 1115 Medicaid Waiver and reflected in committee charters that accompany this document. It should be noted that the Nashua IDN spent considerable time on the development of the governance structure for the demonstration project. This was an intentional process to ease concerns regarding historical collaboration challenges in this community. All members of this IDN entered into this process committed to establishing an evolved, transparent and cooperative approach to the implementation of the 1115 Transformation Waiver. We have been remarkably successful to date and expect we will continue in a positive, productive manner.

The governance structure will consist of an Executive Steering Committee that will serve as the principle governance committee and will serve as the decision-making body. The work of this Committee is supplemented by four subcommittees that will work closely with the Executive Committee and the Management Team of the Administrative Lead, Southern New Hampshire Health.

The quest to create an environment of collaboration and cooperation for providers and service agencies in the Nashua Region began in the early spring, even before the Administrative Lead application was submitted. The rationale for this process was a history of fractured care delivery, fractured relationships, competition, duplication and limited interagency communication. The passion and commitment amongst participants towards creating a substantive and lasting change was evident, but it was also clear that much work would need to be done in the early phases of the IDN that would lay the foundation for future work and for the possibility of creating formal legal entities in the future that might bear participate in risk contracting. There are no formal legal entities that form the basis of the Nashua Region IDN at this time.

As a result, it was decided early on in the process that it would be important to include all interested parties on each of the committees. The result is committees that are larger than conceived in the original construct of the Project Plan Template. However, we believe that long term sustainability of these projects is dependent on a commitment to inclusion and community collaboration.

As such, the initial construct of the governance structure, the nature of the subcommittees, the membership of the subcommittees, the roles and duties of the committees and their members and the voting mechanisms by which decisions will be made were decided by consensus of the full membership of the IDN over a series of meeting which took place in June and July. Various meeting techniques were used in order to ensure input that was participatory and based on a foundation of mutual understanding

and cooperation. As the structure unfolded over this series of meetings, constructs to date were printed on large 24 X 36 inch posters, and participants were invited to dialogue with colleagues around the details during work groups convened during the meeting. This process was not only valuable for yielding the governance charters that are found below, but it also set the stage for inclusive and participatory decision making over the life of the demonstration project.

The convener and facilitator for meetings, for the communication in between meetings and for actual distribution of funds, as allocated by the Executive Steering Committee will be Southern New Hampshire Health who submitted a successful application to serve as the Administrative Lead of the Nashua IDN. The principle members of the Administration Lead Management Team are listed in the table that follows:

Nashua Region IDN Administrative Lead Management Team*	
IDN Executive Director	Lisa K. Madden, MSW Associate Vice President of Behavioral Health Southern New Hampshire Health
IDN Finance Director	Paul L. Trainor Chief Financial Officer Southern New Hampshire Health
IDN Medical Director	Marilou Patalinjug-Tyner, MD Chief Medical Officer Greater Nashua Mental Health Center
IDN Senior Administrative Sponsor	Stephanie Wolf-Rosenblum, MD, MMM, FACP, FCCP Vice President of Development & External Affairs Southern New Hampshire Health

*Note the attached resumes of the four members of the IDN Administration Lead Management Team.

The Administrative Lead Management Team will work closely with the Executive Committee in order to actuate the work of the IDN. A description of the Executive Committee appears below:

IDN Governance: Executive Steering Committee (15 Members)

The members of the Executive Steering Committee shall be selected by the member entities of the Nashua Region 3 IDN and the Administrative Lead Management Team and approved using the Governance Policies of the IDN.

- IDN Executive Director
- IDN Finance Director
- IDN Medical Director
- IDN Senior Administrative Sponsor (Ex-Officio)
- IDN Program Manager (Ex Officio)
- Chair of IDN Financial Governance Committee
- Chair of IDN Clinical Governance Committee
- Chair of IDN Data/IT Governance Committee
- Chair of IDN Community Engagement Committee
- Key Stakeholder Representatives from the following groups if not already represented:

- The Community Mental Health Center
- The Federally Qualified Health Center(s)
- Hillsborough County, representing the nursing home and the jail.
- NH Partnership for Successful Living
- Both Nashua Hospitals and their affiliated practices
- H.E.A.R.T.S. Peer Support Services
- Nashua Public Health Department
- Dartmouth Hitchcock – Nashua
- NAMI (Ex-Officio)
- Gateways

Members are recognized stakeholders and experts in their fields, and in keeping with the Nashua Region 3 IDN Vision and Mission, the Executive Steering Committee will discuss, make decisions, and create policy regarding how best to meet IDN targets and outcomes, based on the input and work of the Subcommittees, including but not limited to:

- Projects that will be implemented by the IDN based on an analysis of data presented.
- Level and distribution of funding to be dispersed to various entities in order to meet the project goals and expectations of selected projects.
- Metrics that will be required to demonstrate success in meeting goals and expectations.
- Final review of all budgets for program proposals.

The Committee will have final and exclusive authority to determine whether to grant a request for an exception to a Nashua Region 3 IDN policy.

The inaugural members will remain in place for 6 months from the contract date of the IDN. Membership will then be reassessed based on the approved Project Plans after which and going forward, members will hold a two-year Committee membership, with renewal option.

The Administrative Lead Management Team shall schedule meetings, establish agendas, preside over Committee meetings, manage membership and member discipline, and ensure that a written record of each meeting is recorded and disseminated appropriately.

By virtue of the presence of the subcommittee chairs on the Executive Committee, there will be excellent information exchange between the 4 subcommittees, the Executive Committee and the membership team of the Administrative Lead. This is crucial as the work of the subcommittees is a vital link in crafting, deploying, monitoring and maintaining project plans. Using the process described above, The Nashua Region IDN has established the following principles for governance to complement the established structure:

Principles for Governance:

- In recognition of the fact that it is always desirable to arrive at decisions by consensus, especially as it pertains to creating a fair, inclusive, and sustainable process, the primary mode of decision-making will be consensus building. For the purposes of achieving this goal, reaching consensus will be defined as the point at which:

- *Other members understand our point of view, and...*
 - *We understand other members' points of view, and...*
 - *The decision was arrived at openly and fairly and is the best solution at this time (whether or not we prefer it).*
- In recognition of the fact that the process of achieving consensus may not be practical for tight timelines and/or for the number and breadth of participants, there will be a back-up mechanism for making decisions based on votes.
 - Decisions about projects or metrics will be decided by a plurality (2/3)
 - A simple majority will determine decisions about finances.
- The IDN voting mechanism will function with **One Agency – One vote** (agencies should only send representatives authorized to vote on behalf of their organization).
- Alternatives to voting in-person will be permitted, as follows:
 - Including but not limited to proxy or e-vote.
 - The parameters of such votes will be determined by the Executive Committee based on the type of decision and the timeliness needed, including but not limited to:
 - Time frame for vote submission.
 - Whether votes may be revisited if a quorum is not established (even when counting the alternative votes).
- For the purposes of the inaugural committees, the Executive Committee will appoint chairs based on their experience and desire to serve. These appointments will be revisited in 6 months' time.
- Going forward, chairs will be decided (consensus or vote) by the Committee members and endorsed by the Executive Committee.

The work of the Executive Committee will be informed by 4 subcommittees, each of which fulfills a vital role in the work of the IDN. A description of each appears below. The construct and membership of the inaugural subcommittees were decided at a series of meetings of the Full IDN, as described above. The full IDN is slated to meet quarterly; meetings for 2017 are being set now. In the interim between meetings, the full IDN is kept apprised of IDN work via electronic means, and they are encouraged to provide feedback or ask questions at any time by contacting the Administrative Lead Management Team and/or any colleagues in the IDN. As appropriate, they are asked to become engaged in the key work of the IDN, as occurred during the distribution and collection of community surveys that is described in detail elsewhere in this document.

The Nashua Region IDN is designed to be as inclusive as possible, having invited all entities to join this effort as long as they provide healthcare or wrap around social services to the target population and agree to the terms of the NH 1115 Waiver. Collectively, the membership of the Executive Steering Committee and the subcommittees was designed purposefully to allow every member a participatory role in shaping the work of this IDN. All members included in this Project Plan have submitted a written Certificate of Authority and Certificate of Vote, and they will be asked to sign the relevant subcommittee charter that commits them to honor and support the work of the IDN as described in this document and

in the policies and procedures of the IDN. This includes adherence to the Compliance Plan and disclosure of conflicts of interest through an approved form and as described in the Conflict of Interest Policy.

Collectively, the IDN will ensure accountability by a combination of the Compliance Plan and a commitment to transparency, as has been established since the first meeting in March. All meeting notes are available to all members and are shared widely through “key points” document that each IDN member is encouraged to share within their agency/organization, as appropriate. Regular reporting within committees, between committees, to the full IDN membership and to the community will occur on a cycle that at least mirrors the required reporting to the state. Practically speaking, this means that every 6 months the IDN members will need to have collected, analyzed, and interpreted relevant data as selected by the committees and as endorsed by the Executive Committee. Furthermore, they will need to have used this information to plan additional activities or to adjust those occurring to ensure that work continues to support performance towards goals and can be understood by the various target audiences contemplated in the plan for community engagement. Part of this process will be to ensure adequacy of the network in serving the behavioral health needs of the Service Region.

Finally, low performers or those who cease to participate in the IDN will be addressed through the IDN’s Compliance Plan.

7b: Four governance subcommittees:

Clinical Governance Committee

The Clinical Governance Committee plays an integral role in the IDN. The Clinical Committee has the responsibility of vetting the project plans and making recommendations for acceptance of, and subsequently implementation of, the projects. It is chaired by an experienced psychologist, Dr. Cynthia Whitaker. There are several other seasoned clinical professionals on the committee. The vetting process will include a thorough review of the proposed plans, the ability to apply evidence based practices, and the ability to provide outcome data that will meet peer reviewed standards. Programs will be reviewed on a quarterly basis and compliance with standards will be demonstrated via the designated outcome tools. The Executive Director and Program Director from the Administrative Lead will work closely with all IDN members to assure outcome measures are met as expected. Modifications to the programs is anticipated as we learn more about what works for the Nashua region. We do not expect our programs to be perfect as currently designed; however, we believe the basic premise for the services is clinically solid and responds to the needs of the community. We also believe these programs will impact the target areas as described and will successfully meet the expectations of the demonstration project.

The charge of this Committee includes:

- Playing an integral role in project plan selection and development of clinical standards.
- Identifying and framing projects intended to address a variety of community needs.

- Developing standard clinical pathways and strategies for monitoring and managing patient outcomes.
- Developing guidance on implementing clinical improvements, including recommendations for relevant education for clinicians in participating agencies on the evidence-based practices or protocols that will be used in the projects.
- Developing and approving clinical reporting for the IDN.
- Developing the strategies for monitoring the implementation Researching, developing and implementing outcome tools that will support the measurement and reporting of metrics.
- Monitoring IDN program performance and determine ways to support IDNs for enhancing outcomes.
- Bringing recommendations for projects and measurements to the Executive Steering Committee for approval.

The inaugural Committee will consist of 17 members in order to fulfill the goal of providing a broad range of perspectives and clinical expertise and experience. It was decided early on in the process that we would include all interested parties on this Committee as the best way to ensure buy-in and follow-through on the practices and procedures selected by this Committee for implementation. The inaugural make-up is as follows:

- Chair of the Clinical Governance Committee, IDN member
- IDN Executive Director
- IDN Medical Director
- IDN Program Manager
- 13 other IDN members representing various treatment and community support services not already represented in members identified above. The inaugural membership of the Clinical Governance Committee is as follows

1. Dr. Cynthia Whitaker, GNMHC - Chair
2. Lisa K. Madden, Executive Director, SNHH
3. Dr. Joe Leahy, Medical Director, ED SNHH
4. Dr. Marilou Patalingjug Tyner, Chief Medical Officer GNMHC
5. Niki Watson, Clinical Director, Lamprey
6. Bobbie Bagley, Director of Public Health, City of Nashua
7. Jill Burns, Keystone Hall (Partnership for Successful Living)
8. Carol Furlong, COO, Harbor Homes(Partnership for Successful Living)
9. Elizabeth Blondeau, Healthy at Home, (Partnership for Successful Living)
10. Norma MacKinley-Smith, NAMI
11. Dawn Reams, Executive Director, Bridges
12. Dr. Donald Reape (Medical Director, St. Joseph Health Care)
13. TBD, Adolescent CarePatti Laliberte, RN, Project Manager, DH-Nashua
14. Dr. William Manseau, Emmaeus Institute
15. Susan Latham, Merrimack River Medical

Financial Governance Committee

In keeping with the Transformation Waiver and with the Nashua Region 3 IDN Vision and Mission, the Financial Committee is responsible for:

- Becoming familiar with the state payment process and ensure that programs are designed in a way that will meet all regulatory (state and federal) requirements.
- Establishing rules for making financial decisions.
- Defining roles and responsibilities of partnering organizations as it relates to financial matters.
- Making decisions on the distribution of funding.
- Establishing the budget for the IDN and IDN projects.
- Monitor budgets and make necessary budget allocation adjustments as the projects evolve.
- Developing and approving financial reporting for the IDN.
- Exploring, understanding and developing alternative payment models.
- Bringing all decisions to the Executive Steering Committee for ratification.

Additional details can be found elsewhere in this report.

The inaugural Committee will consist of 11 members in order to fulfill the goal of providing a broad range of perspectives and financial expertise and experience. It was decided early on in the process that we would include all interested parties on this Committee as the best way to ensure trust and transparency for this critical component of the IDN. The Committee consists of:

- Chair of the Financial Governance Committee, IDN Member
- IDN Executive Director
- IDN Finance Director
- IDN Program Manager
- 7 other IDN members representing various treatment and community support services not already represented in members identified above

The inaugural members are as follows:

1. Greg White, CEO Lamprey –Chair
2. Paul Trainor, IDN Finance Director, CFO, SNHH
3. Lisa K. Madden, IDN Executive Director, SNHH
4. Dick Plamondon, CFO St. Joseph Healthcare
5. Pat Fajans, DH-Nashua
6. Pat Robitaille, CFO, Harbor Homes/Keystone/Harbor at Home
7. Craig Amoth, CEO GNMHC
8. Janis Belmonte, CFO GNMHC
9. Maryse Wirbal, Executive Director, Front Door Agency
10. John Getts, CEO, Home Health Hospice
11. Bob Mack, Nashua Department of Public Health

Data/IT Governance Committee

The Data/IT Governance Committee plays an integral role in the IDN. In keeping with the Transformation Waiver and with the Nashua Region 3 IDN Vision and Mission, the Data/IT Committee is responsible for:

- Determining the processes and standards for data sharing among the partners in the IDN, including the assessment and planning for interoperability and sustainability.
- Providing guidance on the approach to drafting and executing data sharing agreements, including,
 - the issue, review, and evaluation of RFI/RFP with technology providers
 - Meeting with vendors of technology
 - Coordinating data requests and technology projects with assigned IT staff for other community participating agencies
- Developing reporting and reporting processes for the IDN, including
 - Analyzing information from all members of the IDN
 - Determining the types and frequency of reports needed
- Developing monitoring policies and procedures, including for
 - Assessing the status of compliance with the metrics
 - Identifying areas of needed improvement and/or opportunity relative to metrics trends
- Determining the roles of information technology, health informatics, clinical, and administrative leadership within partner organizations will play on overall data governance
- Bringing recommendations for projects and measurements to the Executive Steering Committee for approval.

The inaugural Committee will consist of 11 members with a broad range of perspectives and HIT expertise and experience. It was decided early on in the process that we would include all interested parties on this Committee as the best way to ensure trust and transparency for this critical component of the IDN. The Committee consists of:

- Chair of the Data/IT Governance Committee, IDN member
- IDN Executive Director
- CIO of SNHH
- IDN Program Manager
- IDN Data Analysis
- 6 other IDN members representing various treatment and community support services not already represented in members identified above.

The inaugural members are as follows:

1. Dr. Andrew Watt, CIO/CMIO, SNHH
2. Lisa K. Madden, IDN Executive Director, SNHH
3. Donna Curley, Partnership for Successful Living
4. Miles Pendry, Partnership for Successful Living
5. Patrick Ulmen, CIO of GNMHC
6. Chris Stawasz, Regional Director, AMR Ambulance
7. Will Baum, Quality Improvement Manager, Lamprey Health

8. Glenn Spargo IT Director, St. Joseph Healthcare
9. TBD, Dartmouth Hitchcock-Nashua
10. Deb Krider, Granite State Independent Living
11. Jebb Curelop, Financial Manager, Life Coping

Community Engagement Committee

The Community Engagement Committee will maintain a vital role in the evolution of the IDN throughout the demonstration. In fact, we expect this committee will represent the pulse of the community and drive additional project planning as the needs of the community change over time. There have been many efforts to gather community members to identify, strategize and implement changes in service delivery. It is expected that this Committee will stay engaged and offer critical feedback to the IDN throughout the duration of the Program. There will be additional surveys to assess feedback from the community on the effectiveness of the project plans. There will be ongoing involvement with the Public Health Department as they prepare and implement their extensive Community Needs Assessment. The Community Engagement Committee will bring forth recommendations to the entire IDN for program development. Then, the respective committees will do their part to prepare clinically appropriate programming with the support of the Financial Governance Committee for funding support where applicable. Per the governance structure, all projects will be reviewed and approved by the Executive Committee before implementation.

In keeping with the Transformation Waiver and with the Nashua Region 3 IDN Vision and Mission, the Community Engagement Committee is responsible for:

- Determining how community input will be received and included in the strategic path of the IDN
- Embracing the importance of keeping the entire community engaged, including those who did not meet the full requirements for IDN membership.
- Connecting the community to the transformation process through multiple modalities and determining the channels and venues through which input is solicited.
- Planning and implementing ongoing community forums to seek feedback from community leaders and from within the target population on the progress of the Transformation Waiver implementation, on areas of strength, and on areas that need further development.
- Exchanging knowledge gained with the other governance committees to inform them of the perceptions, interests, and perceived needs of the community at large.
- Determining how the communications strategies will continue throughout the duration of the demonstration project.

The inaugural Committee will consist of 23 members with a broad range of perspectives, expertise and experience. It was decided early on in the process that we would include all interested parties on this Committee as the best way to ensure trust and transparency for this critical component of the IDN. The Committee consists of:

- Chair of the Community Engagement Committee, IDN member
- IDN Executive Director
- IDN Program Manager

- IDN Senior Administrative Sponsor
- Other IDN members representing various treatment and community support services not already represented in members identified above

The inaugural members are as follows:

1. Mike Apfelberg, United Way, Chair
2. Dr. Stephanie Wolf-Rosenblum, SNHH
3. Lisa K. Madden, IDN Executive Director, SNHH
4. Ken Lewis, H.E.A.R.T.S. (Peer Support)
5. Lucy Saia, Director of Care, Home Health and Hospice
6. Patty Crooker, Nashua Public Health Department
7. Damaris Valera, C.O.O. Lamprey
8. Doreen Shockley, Harbor Homes, Housing Support Providers
9. Emily Manire, Gateways
10. Kathy Cowette, St. Joseph's Healthcare
11. Norma McKinley-Smith, NAMI
12. Robert Cioppa, School District
13. TBD, Interfaith Council
14. Maryse Wirbal, Front Door Agency
15. Ann Dancy, Ascentria;
16. Mike LaChance, YMCA
17. Greg Schneider, Southern New Hampshire Services
18. Colleen Flynn, Courville at Nashua
19. Ellen Curelop, Executive Director, Life Coping
20. Meghan Brady, St. Joseph Community Services
21. Jill O'Neill, GNMHC/Community Connections (Drug Court)
22. Sue Meads, GNMHC
23. Thomas Doucette, H.E.A.R.T.S. (Peer Support)

Details of how the Community Engagement Committee will lead the efforts of the Nashua Region IDN to seek input from and engage the community in the work of the IDN appears in detail elsewhere in this report.

7c: Governance charters (charters): Please note the attached Charters for each of the five major Nashua Region IDN governance bodies:

1. Executive Steering Governance Committee
2. Financial Governance Committee
3. Clinical Governance Committee
4. Data/IT Governance Committee
5. Community Engagement Committee

7d: Key IDN management roles: Supplemental Data Workbook, 7D Tab

8. Budget and Funds Allocation (50 points)

8a: Project Design and Capacity Building Funds: Final Budget Narrative

As the Administrative Lead, Southern New Hampshire Health (SNHH) has been working closely with IDN partners to examine the demographics and health status of the target population and to identify gaps in care in order to determine the most effective use of Project Design and Capacity Building Funds. The Nashua 3 IDN has and will be allocating funds toward the following areas for IDN stated and intended purposes:

Development of a Community-Based Behavioral Health Needs Assessment – Greater Nashua’s Community Health Improvement Process includes a 3-year cycle of assessment, improvement and implementation where results were published as the Community Health Assessment (CHA), and the most recent Community Health Improvement Plan (CHIP) is based on these results. Nonetheless, much has happened since the CHA was published in the fall of 2014, and while planning for the process is underway, the next CHA/CHIP is not due to be published until 2017. As such, a specific Behavioral Health Needs Assessment for the 13 towns that comprise the Nashua Region was undertaken and is ongoing. This complemented efforts to update the Nashua Region CHA, but placed added emphasis on behavioral health and SUD, as well as some stratification for the Medicaid and the at-risk for Medicaid populations. Funding was and is being used to create and analyze surveys, as well as to publicize the results in order to inform the work within agencies, to engage non-member entities in enhancing the continuum of care and to elicit additional input from consumers, caregivers and others. Pursuant to the strategic initiatives proposed by the Community Engagement Committee, funds will be used to advertise, sponsor and staff community forums, to facilitate and participate in meetings with stakeholders, and to gather and document community input. Other funds will be used to create transparent, informative and, where possible, 2-way communication channels about the work and goals of the IDN. Resources will be dedicated on an ongoing basis to further refine analyses of gathered data and to draft, prepare and disseminate the findings from these activities amongst members of the IDN, as well as to the community.

Development of IDN Project Plan - The development of the Project Plan serves as the foundation for transforming the delivery of behavioral health and substance misuse services in the Nashua region. As such, SNHH allocated funding for dedicated resources to convene meetings among IDN partner organizations, where members collaborated to select and develop the three community projects proposed in this document. The planning phase to date has included establishing governance among the partner organizations and developing the outlines of an implementation plan; work is ongoing and will require considerable effort on the part of all Participants. This includes

- Review of data gathered through the assessments and surveys described above, including gaps in care and barriers to achieving progress.
- Development of strategies to address work force needs for behavioral health and SUD treatment.

- Research into evidence-based practices and national best-practice clinical models including established protocols and training and benchmarks for following the impact of changes.
- Review and sharing of existing clinical, financial, governance and IT practices, capacity experience and expertise of participating Nashua Region IDN partners *and* the other IDNs throughout the state.
- Planning for the development of new clinical, financial and governance approaches for the IDN, taking into account both the present state and the future state needed to accomplish the selected work over the duration of the demonstration project.
- Development of strategies to optimize the limited resources available to address the behavioral health and SUD treatment needs of the community.
- Identification of and developing specifications for measurable outcomes that will show increased capacity in behavioral health and substance misuse, and to
- Collaborate to define the appropriate technical requirements and infrastructure to share data amongst the partner organizations, to report outcomes and to share data with DHHS.

Capacity Building for Direct Care or Service Provision Workforce: Recruitment and Hiring –

Funding will be allocated to support the recruitment and hiring of front line staff needed to fill identified gaps in the types of professionals needed to accomplish the improvement work. The focus will be the expansion of services needed to support the priority projects identified by the IDN and outlined in this document. It is anticipated that direct care staff needed to support transformation and the continuum of behavioral health and substance misuse care will span a range of clinicians, from physicians to nurse practitioners to licensed mental health and addiction counselors to social workers. Funding will support the necessary functions associated with hiring of resources, including the development and updating of appropriate job descriptions, advertising of positions, interviewing, relocation fees, sign-on bonuses, recruitment fees, licensing fees and onboarding of new staff across the partner organizations.

Capacity Building for Direct Care or Service Provision Workforce: Retention of Existing Staff

IDN members understand that success of the identified projects will be contingent on the stability of the existing and established workforce. Funding for retention of existing behavioral health professionals will be aimed at ensuring stability throughout this transformation process. IDN members further recognize that retention of skilled workforce faces a triple challenge: 1) unemployment is at an all-time low, particularly in New Hampshire, 2) compensation is often higher just over the border in Massachusetts, and 3) many and varied IDN members have unmet workforce needs. In order to maintain the stability of the workforce and fulfill the projects as planned, funds will be allocated to make necessary market adjustments to ensure that compensation remains competitive. Funds will also be used for professional development programs and cross-training initiatives, as deemed appropriate and desirable by IDN members and as informed by the State-wide initiatives.

Capacity Building for Direct Care or Service Provision Workforce: Training

Funds will be allocated for training, retraining or enhancing skill sets of new and existing direct care staff, with an emphasis on behavioral health care, SUD treatment and social services. Funds will assist in identifying training needs, in developing appropriate curricula and in creating various learning opportunities to deliver those resources to the staff that will help close service gaps and shortages. As part of this initiative, funds will also be allocated to training key front-line people in the community in identifying a behavior health or substance misuse disorder and in directing care to the most appropriate setting.

Establishment of IDN Administrative/Project Management Infrastructure

Funds for this aspect of the infrastructure will be targeted toward ensuring the success of the IDN. Funds will be allocated for the Executive Director, the Finance Director, and the Medical Director to oversee the governance committees and to monitor the success of the project. Funds will also be allocated to establish a full-time project manager, a data analyst, and a part-time administrative assistant to manage and perform the administrative functions throughout the transformation project and on behalf of its dozens of members. Funds will also support the work of the Executive Steering Committee and the four governance subcommittees, which represent a diverse cross section of all partner organizations and will be critical to the success of the transformation of the care continuum for behavioral health and substance misuse disorder. These leaders and committees have and will use funds to establish and enhance communication, create project management protocols, engage consultants where needed, and to create the systems necessary for planning, implementing, monitoring, reporting and improving upon IDN activities.

Health Information Technology/Health Information Exchange

Funds will be allocated for investments in critical Health Information Technology/Exchange infrastructure when existing infrastructure and platforms, including those available through the New Hampshire Health Information Organization (NHHIO), are insufficient to support the work of the IDN. These investments will be largely informed by the work of the State-wide Task Force and may include:

- Developing, enhancing or interfacing of electronic health record systems
- Creating registry capacity
- Embedding standardized assessments, taxonomy and defined data fields/elements into existing systems and across multiple stakeholders
- Enabling treatment and care transition documents to be shared across IDN partners

Funds will also be used to establish the appropriate measurement data points in order to monitor and report progress throughout this transformations process.

The ultimate focus and weight of each of these fund allocations will likely evolve as projects selections are refined, based on updated and expanded needs assessment(s), input from the Task Forces, and guidance from the Independent Assessor and feedback from the Independent Review Panel.

8b: Final projected budget estimates: Supplemental Data Work Book, 7D tab

8c: 5-Year IDN Incentive Funding: Funds Allocation Governance:

The full IDN, consisting of a broad group of primary care, mental health and SUD providers, community leaders, and agencies delivering services that address the social determinants of health were engaged in and were able to reach consensus for this process. Key elements included creating the construct for the Financial Governance Committee, the governance rules that will inform the process by which decisions will be made about the distribution of funds earned by IDNs over the course of the demonstration and for the role of the Nashua Region Administrative lead in fund distribution. All elements were refined and approved by the Executive Steering Committee.

The IDN's Financial Governance Committee is described in detail in the governance charters that accompany this Project Plan Proposal document. The Committee includes representation from key stakeholders in the IDN, including both Federally Qualified Health Centers, the Community Mental Health Center, both Nashua hospitals, all 3 of the large multispecialty practices (St. Joseph's, Foundation Medical Partners, and Dartmouth- Hitchcock), along with the Public Health Department and a social service agency. The roles of this Committee include:

- Becoming familiar with the state payment process and ensuring that programs are designed in a way that will meet all regulatory (state and federal) requirements.
- Establishing the rules for making financial decisions, based on the Principles of Governance approved by the Executive Steering Committees.
- Defining roles and responsibilities of partnering organizations as it relates to financial matters.
- Making decisions on the distribution of funding.
- Establishing the budget for the IDN and IDN projects, based on the input and information provided by the Clinical Governance and IT Committees, and other committees and workgroups, as appropriate.
- Monitoring budgets and making necessary budget allocation adjustments as the projects evolve.
- Developing and approving financial reporting for the IDN.
- Exploring, understanding and developing alternative payment models.
- Bringing all decisions to the Executive Steering Committee for ratification.

The various IDN partners who are in the position to/wish to respond to specific selected Community Projects, who have funding needs relative to their obligations to meet the standards of the mandatory projects (Workforce, HIT, integration/core competency) make their needs known through submitting proposals (with proposed budgets, where applicable), responding to surveys or participating in formal committees or informal work groups. These proposals will be considered, based on the different organizations roles' and ability to help achieve desired metrics and outcomes, and this information will be used to develop project budgets and a fund allocation plan. The plan will then be brought to the Executive Steering Committee for discussion and approval. The process will proceed according to the following governance principles and voting mechanisms approved by the IDN:

- In recognition of the fact that it is always desirable to arrive by decisions by consensus, especially as it pertains to creating a fair, inclusive, and sustainable process, the primary mode of decision-making will be consensus building. For the purposes achieving this goal, reaching consensus will be defined as the point at which:

- Other members understand our point of view, and...
 - We understand other members' points of view, and...
 - The decision was arrived at openly and fairly and is the best solution at this time (whether or not we prefer it)
- In recognition of the fact that the process of achieving consensus may not be practical for tight timelines and/or for the number and breadth of participants, there will be a back-up mechanism for making decisions based on votes.
 - decisions about projects or metrics will be decided by a plurality (2/3)
 - a simple majority will determine decisions about finances.
 - The IDN voting mechanism will function with One Agency – One vote
 - Representation from IDN partners acknowledge that they can act on behalf of their agency
 - Alternatives to voting in-person will be permitted
 - Including but not limited to proxy or e-vote.
 - The parameters of such votes will be determined by the Executive Committee based on the type of decision and the timeliness needed, including but not limited to:
 - Time frame for vote submission
 - Whether votes may be revisited if a quorum is not established (even when counting the alternative votes).

The IDN's rationale and justification for this financial governance approach and funds allocation process is based on the substantive work that has been accomplished in the Nashua Region IDN since the first meeting of potential member entities in March 2016 to create an inclusive and transparent process meant to build trust and relationships that were missing or broken in the Greater Nashua area. It is the consensus of members that this chosen approach is best positioned to support the IDN in successful implementation of its projects and achievement of its performance metrics over the lifetime of the demonstration project

8d: 5-Year IDN Incentive Funding: Funds flow to shared partners:

The Greater Nashua Integrated Delivery Network for New Hampshire's Section 1115 Medicaid Demonstration Waiver (the "Nashua IDN") is fully committed to conducting its activities in compliance with all federal, state and local laws and regulations and in conformance with the highest standards of business integrity. For this purpose, the Executive Committee of the IDN has endorsed a Compliance Plan and accompanying Compliance Statement (attestation) that is *designed to guide all member entities of the Nashua Region IDN to maintain compliance with New Hampshire's Department of Health and Human Services' program requirements related to the Section 1115 Medicaid Demonstration Waiver, prevent and detect violations of law, and/ or criminal conduct by our employees and agents, as well as to demonstrate due diligence in these areas.* The Nashua IDN's Compliance Plan applies to all staff of the Nashua IDN's Administrative Lead, all staff of the Nashua IDN's member entities ("Member Entities"), and vendors providing services to or on behalf of the Nashua IDN (collectively, "Participants"). This Nashua IDN Compliance Plan summarizes the structure, key elements and compliance procedures of its compliance program.

Specifically, with regards to addressing the expectation that providers participating in multiple IDNs will not receive duplicative payments for providing the same services to the same beneficiary through a project activity, the following has been included as a part of this Compliance Plan:

Duty to Act in an Ethical Manner

The Nashua IDN, each of its Member Entities and their Staff will be responsible, trustworthy, honest and reliable while representing the Nashua IDN. The Nashua IDN, each of its Member Entities and their Staff shall conduct his or her business activities in an ethical manner and shall comply with the ethical business practices adopted by the Nashua IDN, including, but not limited to those set forth in all policies and procedures adopted by the Nashua IDN, this Nashua IDN Compliance Plan and each Member Entities' respective policies, as applicable.

The Nashua IDN and its Participants will make every reasonable effort to ensure that billing and coding is accurate, timely, and in compliance with federal and state laws and regulations, as well as that reimbursement is only sought for services covered by the Waiver.

The Nashua IDN and its Participants will make every reasonable effort to ensure claims are not submitted that contain any kind of false, fraudulent, or inaccurate statements. Staff who lawfully report a concern are protected from retaliation by these same policies, as well as federal and state laws governing false claims.

In addition, in its role as Administrative Lead, Southern New Hampshire Health will establish DSRIP departments to track the receipt and distribution of DSRIP funds. The Executive Director and the Project Manager will be responsible for reviewing the DSRIP departments. Disbursements of earned DSRIP funds from SNHH will require approval from the Executive Director or Project Manager prior to payment and must be within the established budget and within the parameters of the allowable expenses outlined in Appendix A of the Application. Generally accepted accounting principles that are well established and audited yearly will be applied to the DSRIP funds distribution process. As such, the accounting system has controls to restrict duplicate payments made to vendors. An accounting will be provided to the Executive Steering Committee on an established schedule.

Language in the Compliance Plan also supports a process for reporting and addressing concerns or complaints. For those processes that involve funds from the Nashua Region IDN, the process provides for these to occur both through the member entities' compliance processes as well as through the IDN Corporate Compliance Officer in consultation with the Executive Committee.

9. Alternative Payment Methods (5 points)

SNHH has been participating in APMs through Population Health Management ("PHM") for several years in preparation for the transition from volume to value and believes that it is well positioned to help guide the Nashua Region IDN through this transition. The work to date accomplished by SNHH addresses the transition to the recently published Medicare Access and CHIP Reauthorization Act ("MACRA"). Some of the work relative to APMs that SNHH has accomplished includes:

- All of the SNHH's primary care practices have achieved Patient Centered Medical Home Designation by NCQA.

- SNHH is a member of New Hampshire Accountable Care Partners ACO that participates in the Medicare Shared Savings Program (“MSSP”) phase 1.
- SNHH has 24 Care Coordinators focused on managing high-risk chronic disease patients.
- SNHH has value-based contracts in place for the majority of our payers; including Medicare (MSSP), Anthem, CIGNA and Harvard Pilgrim.
- SNHH performance under these contracts has been favorable.
- SNHH value based contracts have been limited to upside shared savings. To date, the Health System has not entered into any “downside” risk agreements.
- SNHH is part owner of Tufts Health Freedom Plan.
- SNHH works with our Partners at Granite Health (“GH”) to establish broader risk pools, share analytic tools and to promote shared learning.
- SNHH has in place the IT infrastructure to comply with the Advancing Care Information requirements.
- SNHH has in place advanced analytics both locally and through GH to succeed in quality reporting.
- SNHH has in place an operational structure (Leadership, project management, analysts) to advance quality activities and other process related improvements.
- SNHH has a highly aligned multi-specialty provider organization, inpatient, outpatient, nursing home, and home care to address all patient needs regardless of location of care.

SNHH will look to leverage its PHM investments to maximize performance under MACRA with the plan to migrate to the APM bonus program under MACRA. Approximately 70 % of SNHH’s patients belong to an APM, however revenue from APMs account for less than 1% of SNHH’s revenue.

Other IDN members have also participated in APMs to a varying degree. The following table summarizes their experience.

Nashua Region IDN Partner	APMs					
	Bundled payments	PCMH primary care payments w/shared savings	Population-based payments for condition-specific care	Comprehensive population-based payment models	Fee for Service Model	Other
AMR (American Medical Response)	1	0	0	0	99	0
Ascentria Care Alliance	Follow up email sent					
Bridges	0	0	0	0	50	50
City of Nashua/Public Health	N/A					
Courville at Nashua	0	0	0	0	45	55
Dartmouth Hitchcock Nashua	0	0	0	0	92	8
The Emmaus Institute, Inc.	0	0	0	0	100	0
Foundation Medical Partners	0	0	0	0	98	2
The Front Door	0	0	0	0	50	50
Gateways	1	0	0	0	88	11
Granite State Independent Living	0	0	0	0	90	10
Greater Nashua MH Center	0	0	0	0	100	0
Harbor Homes	0	0	0	0	100	0
Healthy Home, Inc.	0	0	0	0	100	0
H.E.A.R.T.S. Peer Support Center	0	0	0	0	0	100
Home Health and Hospice	0	0	0	0	100	0
Keystone Hall	0	0	0	0	100	0
Lamprey Health Care	0	4	0	0	96	0
Life Coping, Inc.	Email follow up sent					
Merrimack River Medical Services—Community Substance Abuse Centers	5	0	0	0	67	28
NAMI (National Alliance on MH) NH	0	0	0	0	0	100
Southern NH Medical Center	0	0	0	0	98	2
Southern NH Services	N/A					
St. Joseph Community Services	N/A					
St. Joseph Hospital	0	10	0	0	90	0

United Way of Greater Nashua	0	0	0	0	0	100
The YMCA	0	0	0	0	92	8
The Youth Council	0	0	14	0	13	73

Section II: Project-level Plans

10. Project AI: Behavioral Health Workforce Capacity Development (25 points)

10a: IDN workforce project leads and participants, Supplemental Data Workbook, 10A Tab

The members of the IDN Workforce project have not yet been designated. At the present time, Lisa Madden, in her role as the Executive Director, and Stephanie Wolf-Rosenblum, in her role as Senior Administrative sponsor for SNHH have been attending meetings, reviewing documents and keeping other IDN members apprised of the process.

The intent is to have this effort led by the Project Manager, once identified, and to designate participants once the scope of the Task Force is further elucidated.

Of note, the Excel spreadsheet appears to have an error. Names cannot be added although they can be inferred from the email addresses. Likewise, options for downstream columns appear limited to yes/no.

10b: Narrative describing IDN's workforce capacity challenges:

Workforce needs are significant, which will require a timely, systemic approach based on all identified IDN-level and statewide workforce gaps. IDNs will participate in two state-led, state-wide projects; one to develop health information technology infrastructure to support integration, which is addressed below, and a second to strengthen mental health and SUD workforce. The state workforce project will balance IDN staffing needs with strategic workforce planning, create a demand-driven model to meet the needs of the IDNs, and deploy resources to meet project goals, taking advantage of systemic processes and efforts already in place. As stated in the Workforce Development for Building Capacity 1115 Transformation Waiver 9.23.2016 presentation, "the end goal is not the plan but to staff needs in order to move the dial."

Drawing on the local Community Needs Assessment data in the area of workforce capacity challenges, and focusing on the areas of recruitment, hiring, training, and retention, Nashua Region IDN members overall cited increasing workforce in the field as a vital, strategic element to the Project Plan. Current shortages create a barrier to effective patient treatment. This includes but is not limited to the availability of psychiatrists, psychiatric nurses, PCPs comfortable with mental health/SUD, psychologists, school psychologists and psychiatric nurses, corrections psychologists and psychiatric nurses, therapists, SUD counselors, and "front line" staff members.

Demand is high because of the growing complexity of services and the dramatic and tragic rise in deaths over the last few years in New Hampshire. Actions need to be timely in implementation.

Recruitment needs to recognize the tight employment market and incentives need to be competitive. Members expressed concern overwhelmingly with the smaller pool of younger workers because simply there are fewer of them. Members also cited the aging of current workers as exacerbating the problem. Establishing an applicant pool accessible across member entities would be a valuable tool to share and leverage scarce workforce talent and skill sets.

Human resource managers and hiring managers need to recognize market needs and the desire for potential employees to secure a position with competitive salary and benefits. Compensation for behavioral health providers has been notoriously poor. Professionals with a master's degree, independent licensure, and years of experience make as little as \$40K a year. Also, the promise of advancement within the field is too often limited and stifles retention.

Crippling expectations for licensure for mental health professionals who come from another state must be addressed. New Hampshire does not provide reciprocity with other states, not even the bordering states of Massachusetts, Maine, and Vermont. Until regulatory relief is achieved, successful expansion of the workforce will also depend on professional development for those already licensed in the state but who lack the necessary skills to participate in the care of beneficiaries with complex needs.

The advancement of telemedicine as a means to treat/monitor patients who have accessibility issues will help to alleviate workforce needs somewhat in the Nashua Region IDN but will not diminish the need for additional, proper training because of the high reliance on a defined level of proficiency in technology skills. Privacy concerns and the need to secure patient consent to honor patient confidentiality remain issues to be worked out as telemedicine gains a foothold. Nashua Region IDN members support the exploration of telemedicine as a viable strategy to address workforce needs, not only to serve more rural patients but also to meet needs in more densely populated areas

10c: Narrative describing expected IDN efforts to address workforce capacity challenges:

The outline below summarizes the Nashua Region IDN workforce capacity challenges and planned actions to address those challenges. The priorities and focus of the work of IDN members will be designed to augment and supplement State-Wide work force initiatives, including those aimed at creating regulatory relief, in order to meet local needs.

Challenges

Workforce capacity challenges: Attraction and Recruitment

- Lack of recognition of public health as a desirable, honorable, and valued career choice.
- Lack of marketing among high school and college students about availability of potentially long-term career opportunities.
- Lack of diversity among skilled mental health/SUD professionals that should reflect Nashua Region IDN communities.
- Lack of electives or practicum at local colleges specifically for those pursuing a career as skilled mental health/SUD professionals.

Workforce capacity challenges: Hiring

- Few financial incentives for skilled mental health/SUD professionals, particularly “front-line” staffs
 - Low pay
 - Few benefits
- Expansion of vocational licensing

Workforce capacity challenges: Training and Career Development

- Lack of training for non-clinicians
- Lack of workforce readiness
- Lack of training to instill confidence and competence to becoming more proficient in using electronic record-keeping tools

Workforce capacity challenges: Retention

- High workloads per staff member
- Lack of more formal succession planning that ensures development of leadership
- High rates of burnout, especially in an environment where access is poor leading to longer hours and higher patient loads for the remaining professionals

Actions

The outline below includes actions that the Nashua Region IDN anticipates pursuing, in collaboration with colleagues throughout the IDN and state-wide. Priorities will be selected through the governance model and will be predicated on the final construct of the Project Plans. The degree to which other entities (universities, public health, legislature) undertake initiatives that impact workforce shortages in the mental health and SUD realm will inform the work of the local IDN.

Actions to alleviate workforce capacity challenge: Recruitment

- Promote and market public health as a desirable, long-term career choice.
- Increase marketing among high school and college students by offering entry-level training programs that lead to licensing/certifications and entry-level employment opportunities.
- Increase recruitment efforts to already employed, skilled professional health care staff already working in other health care fields to replace the current, aging mental health/SUD workforce
- Lower or waive licensing fees if successful in fulfilling requirements.
- Develop opportunities for peer support specialists, family peer support specialists, recovery specialists, youth peer support specialists.

Actions to alleviate workforce capacity challenge: Hiring

- Realign salary and benefits for mental health/SUD employees along the lines of other health care professions to be more competitive.
- Reimburse licensing fees upon the hire of LNAs who take medical certification program and/or create a mental health/SUD specialty
- Reduce complexity of state licensure process to decrease time to becoming registered practitioner; establish licensure reciprocity for border states; develop alternative certification programs that recognize extensive related work experience.
- Expand state liability coverage for mental health/SUD professionals, FSS workers, PCSPS and LNAs to drive clients to appointments and run errands.

Actions to alleviate workforce capacity challenge: Training

- Increase access to online training in Mental Health First Aid for non-clinicians.
- Expand electives or practicum at local colleges in mental health care/SUD fields.
- Expand online courses for flexibility to enhance skills and knowledge and leverage open-sourced materials as appropriate.

Actions to alleviate workforce capacity challenge: Retention

- Expansion of workforce needs will be addressed and coordinated in conjunction with priority areas of need.
- Coordinate trainings among Nashua Region IDN members to maximize opportunity and better monitor the meeting of skill sets needed to alleviate common areas of workforce shortage.
- Establish shared database of potential employees that includes resumes.

11. Project A2: Health Information Technology (HIT) Infrastructure to Support Integration (25 points)

11a: IDN HIT project leads and participants: Supplemental Data Workbook, 11A Tab

The IDN Data/HIT project is presently being led by the CIO/CMIO of the Administrative Lead, Southern NH Health. The intent is to have this effort led by a non-SNHH member entity, once the scope of the HIT Task Force is further elucidated.

Of note, the Excel spreadsheet appears to have an error. Names cannot be added although they can be inferred from the email addresses. Likewise, options for downstream columns appear limited to yes/no. For this reason, additional names were not added but can be found in the governance section 7b.

11b: Narrative describing IDN's HIT gaps:

To keep ahead of where we need to be with implementing a fully integrated, high standard of care health care system, Nashua Region IDN members are working toward a more comprehensive means to exchange information. Even before a State-wide HIT resource assessment is complete; we know that our IDN members use multiple HIT platforms. Even Southern New Hampshire Health, as Administrative Lead, supports multiple platforms because no single platform or vendor meets all the needs for business and clinical workflow. Therefore, the IDNs HIT group will concentrate on and work with the State HIT Taskforce around data transition to support the overall IDN goal of improved care transitions. To do so requires establishing a robust, high-tech infrastructure, connecting to a responsive network superior in its reliability to handle high demand for data and video and technology-competent staffs who receive ongoing training to keep current with the accelerated pace of upgrades and advancements for the user. At the same time, we need to uphold patient rights to confidentiality in this burgeoning era of digital record-keeping.

Innovation in the field of health care record-keeping has the great potential to making our regions healthier and our communities safer and smarter. Toward that end, Nashua Region IDN partners have identified and linked activities that build on the NHHIO initiative, led by Southern New Hampshire Health CIO/CMIO and Vice President of IT and Services Dr. Andrew Watt.

Here below are the NHHIO strategies that will guide IDN activities:

1. Establish a sustainable organizational, governance, and technical foundation for achievement of long term statewide health information goals;
2. Level-set individual providers' abilities to meet Stage 2 Meaningful Use criteria by facilitating ePrescribing, lab results delivery, and patient care summary exchange across the state;
3. Catalyze the efforts of programs focused on HIT adoption;
4. Expand availability of HIE services to providers that do not currently have access to robust capabilities for health information exchange; and
5. Collaborate with Legislators to define the future policy governing HIE purpose and participants.

Southern New Hampshire Medical Center and Foundation Medical Partners, 2 member entities responsible for a significant Medicaid population, recently began receiving C-CDA clinical information from two community partners, Lamprey Health Care and Harbor Homes. More community-based organizations need to be supported and added to create a more comprehensive, all-inclusive network of contributors. Because of the focus on behavioral health and SUD, the Nashua Region needs to collaborate within NHHIO and based on the specifications that are derived from the work of the State-Wide HIT Task Force to differentiate levels of patient consent for information sharing needs between primary care and specialty care with the goal of creating a more automated and clinical-sophisticated IT system.

11c: Narrative describing expected IDN efforts to address HIT gaps:

IDNs will participate in two state-led, state-wide projects; one to strengthen mental health and SUD workforce, as noted earlier in this Plan, and a second to develop health information technology infrastructure to support integration. The seismic shift to digital, web-based health information record-keeping is key to an effective integrated health care system. IDN efforts, informed by the long-standing work of NHHIO and built around the specifications identified by the State through the engagement of the HIT Task Force (as led by the consultants, Myers and Stauffer) will address HIT gaps. As part of this effort, priorities will be built around lessening reliance on antiquated health records management systems; creating a network superior in reliability; and promoting professional development opportunities to keep technology competent staffs current in their work skills.

The promise of HIT to address the records management burden is highly motivational to all health care providers. Providing more time to focus on care transitions for patients moving between health care organizations and agencies is the impetus to change. At present, NHHIO is working within the state

regulations to identify an easily accessible standardize framework for exchange. Endorsing such an established system saves significant cost by not having to replicate the exchange and provides a low cost point of entry for many community organizations. Because NHHIO is operating state-wide, it also provides a framework for communication between not only IDNs but also between states. At present, all health care entities are limited by state law in terms of allowable exchanges via NHHIO, but it makes practical sense to use federal standards, proven to provide secure health care communications to interface and exchange data. Information transitions introduce opportunities for error, and in most cases a physician will repeat work where there is low confidence in information or if the information is not present when the patient is being seen. Cross-border issues and connection to federal healthcare delivery system will reduce the possibility of error or incomplete data.

Each member of the Nashua Region IDN will work to create an environment and infrastructure that supports fellow members in taking the steps to become a part of the digital network to share appropriate information. It is a critical means of ensuring that a health care provider or agency is accessing appropriate information so that the patient is receiving appropriate treatment, especially if the patient needs a specialized service or is seeking services from multiple locations. More substantive plans will be designed once the results of the HIT assessment tool are completed and analyzed.

12. Project B1: Integrated Health (Core Competency) (100 points)

Integrated behavioral and physical health care has been proven to be the most effective approach to improving a patient's overall health and wellness. The members of the Nashua IDN have committed to participating in an integrated behavioral and physical treatment model. We recognize members are at various stages of implementation; however, all understand the minimum standard is a collaborative model with the expectation of becoming fully integrated by the end of the demonstration project. Those members with a higher Medicaid population on their panels are required to meet the fully integrated standards within the first year.

12a: Current-state assessment of network specific to Core Competencies: Supplemental Data Workbook, 12A Tab

12b: Participating organizations: Supplemental Data Workbook, 12B Tab

12c: Monitoring plan:

Improving the quality of care for patients is fundamental to this Project Plan. The Nashua Region IDN joins fellow IDN regions in the state of New Hampshire to implement the Core Competency Project of Integrated Health, which will involve primary care providers, mental health and SUD providers, and social services organizations partnering to

- prevent, diagnose, treat and follow-up on both behavioral health and physical conditions
- refer patients to community and social support services
- address health behaviors and healthcare utilization

The Nashua Region IDN is a solid, comprehensive network representing many service lines. Members of the network represent the key areas of need as defined by the state (primary care, mental health and

SUD, and social support service providers) to deliver care in a much more coordinated and integrated way. IDN members are committed, voicing support for integrated health during multiple community meetings convened by the Administrative Lead, Southern New Hampshire Health (SNHH), to discuss the IDN Project Plan. Their belief in moving to an integrated health model is evident, and they are committed to the promise of improved access, quality of care, efficiency of care, and patient satisfaction at a more reasonable cost.

They are willing to work together to meet standards defined by the state:

- Core standardized assessments for depression, substance use, and medical conditions
- Integrated electronic medical records and patient tracking tools
- Health promotion and self-management support
- Care management service

Several members of the IDN have invested already in integrated care treatment models. Greater Nashua Mental Health Center (GNMHC) provides clinical support to physicians practicing with Dartmouth Hitchcock; the Partnership for Successful Living has on-site programs that provide medical care, psychiatric services, and dental care; and Lamprey Healthcare has a history of successfully implementing integrated care through a federal grant. Keystone Hall, a member agency of the Partnership, has committed to providing treatment for substance use disorder patients. The IDN also has the support of the Mayor's Opioid Task Force, which is comprised of dozens of community leaders, providers, people in recovery and concerned citizens. This group also offers access to self-help entities and other community supports. H.E.A.R.T.S. will bring the skills and compassion of peer support and family education to the IDN, as will the Nashua chapter of the National Alliance on Mental Illness (NAMI). The court system, law enforcement, fire and rescue, and the public school districts are all committed to supporting the IDN Project Plan and integrating health care in the region.

Monitoring is key to ensuring the fidelity of implementation and outcomes to maintain and sustain the effectiveness of a patient-centered, integrated delivery of care. To guide the building of dedicated resources in support of the move to a more integrated delivery of care, Southern New Hampshire Health, the Nashua Region IDN Administrative Lead, recently established two new leadership positions:

Associate Vice President of Behavioral Health
Vice President of Development and External Affairs

In July 2015, prior to public knowledge of the 1115 Waiver, SNHH invested in a strategic position to ensure that behavioral health services within the Health System were connected to each other and to the greater community. Lisa K. Madden, a trained social worker and proven leader in behavioral health, was named Associate Vice President of Behavioral Health. She is responsible for the implementation of high quality behavioral health services including ACCESS, BHU, PHP, IOP, Foundation Collaborative Care, and Integrated Care in the PCP offices. In this role, Lisa is directly responsible for the front line staff that care for patients and that refer patients to other health care providers and providers of social services. In weekly meetings, Lisa engages these staff in robust discussions of the real time experiences of providers and patients during acute episodes, during transitions in care, and during health maintenance visits. In addition, a key component of this role is to collaborate with community leaders, as we all work to improve the access and scope of behavioral health services throughout the region.

Dr. Stephanie Wolf-Rosenblum joined the Southern New Hampshire Medical Center medical staff in 1988. She has served in various senior leadership roles, including Medical Director of Foundation Medical Partners, Chief Medical Officer of Southern New Hampshire Medical Center, the BOD of Greater Nashua Mental Health Center, and Chair of the NH Quality Assurance Commission and of the Foundation for Healthy Communities. Since starting this new role as Vice President in November 2015, again, in advance of the 1115 Waiver, she has worked tirelessly to advocate for behavioral health resource on a state and local level. Dr. Wolf-Rosenblum has strong relationships with many community leaders and will serve as the Senior Administrative Sponsor for the Nashua Region IDN.

This type of connectivity, from front line staff to leadership, provides an ongoing view of the continuum of care in real time. This will be instrumental in supplementing the relationships, the governance structure and roles, the work of the subcommittees and the Compliance Plan in monitoring progress of and engagement of various member entities in the work of the IDN.

In addition to providing leadership support, Southern New Hampshire Health (SNHH) has chosen to lead by example by demonstrating a continual investment in behavioral health services. During a time when many health care organizations have chosen to reduce or eliminate behavioral health services, SNHH chose to invest their limited financial resources into expanding and strengthening behavioral health in significant ways and is poised to lead efforts supporting integrated delivery of care and increased access and scope:

Expanded inpatient Behavioral Health Unit (BHU) from 13 to 18 beds, August 2015

SNHH increased capacity by nearly 40%, including beds for detoxification when appropriate for the patient.

Substance Misuse Intensive Outpatient Program (IOP), July 2015

This program provides a comprehensive evaluation followed by a 16 session intensive group treatment process. Weekly aftercare is also available. The program follows the American Society of Addiction Medicine (ASAM) criteria. As of the end of April 2016, 102 people were evaluated, 41 completed the 16 sessions, and several participate regularly in the aftercare group.

Partial Hospitalization Program (PHP), 2013

The PHP provides a structured program of outpatient psychiatric services as an alternative to inpatient psychiatric care for clinically eligible patients. SNHH expanded the hours and hired staff to support the program staying open 7 days a week.

Foundation Collaborative Care, January 2015

Foundation Medical Partners (FMP) now employs a psychiatrist and psychiatric nurse practitioner to evaluate patients, stabilize medication needs, and consult with the PCP to support ongoing care in the Patient Centered Medical Home. This service provided expert consultation to over 700 patients in the first year of implementation.

Patient Centered Medical Home (PCMH), 2013

FMP carries nearly 74,000 patients on its panels. To effectively manage their needs, FMP became certified as a Level 3 PCMH in all 22 of its primary care practices. Services include: integrated clinical care; embedded Care Coordinators who work extensively with community resources to facilitate

patients' medical and behavioral health needs; and Social Workers who work with patients that have multiple needs.

With each of these recent investments in behavioral health services, Southern New Hampshire Health has met goals and measured success for a more optimal quality of care for patients. This work will be shared widely with IDN members to foster progress in achieving care integration.

During formal meetings of the IDN, especially the Clinical and Executive Committees, members of the IDN agreed on the importance of developing procedures to evaluate all established and emerging services according to Substance Abuse and Mental Health Services Administration (SAMHSA) guidelines. SAMHSA strongly recommends developing procedures and following through with frequent supervision and evaluation of the performance of integrated treatment specialists. According to SAMHSA, "Identifying professional development so that the specialists understand and consistently apply the evidence-based practices for treating people with co-occurring disorders or identifying further leadership, training and accountability is imperative to reaching goals and sustaining effective treatment." Leaders need to provide weekly group supervision to integrated treatment specialists. Group supervision should review beneficiaries involved in the Integrated Treatment program and problem-solve ways to help them better meet their individual goals.

All of the above will be used to inform the Project Plans as they pertain to achieving integration according to evidence-based standards.

12d: Expected Outcomes:

The goal is to strengthen the network of health care connectivity. The Nashua Region IDN will mitigate risks to meeting the goal by becoming engaged fully in the two state-wide projects dedicated to

- Strengthening mental health and SUD workforce ,and
- Developing and implementing health information technology infrastructure to support integration and help coordinate care of patients.

The expected outcome is a system of information retrieval and exchange that would specifically monitor patients' patterns of multiple ED visits, record diagnoses at each medical encounter, list ED care plans with a list of patients' medical providers, and link in to a patient's prescription data, including opioid prescriptions.

Once again as noted earlier in this Project Plan, having a workforce competent in using electronic record-keeping tools is fundamental to integrated care. User ease is important to ensure case managers and outpatient providers upload care plans that can be shared across all participating health systems. A comprehensive electronic record-keeping system needs to be equipped with the ability to transmit alerts via email, phone, fax, text, or directly with the ED interface about a patient's well-being, bringing immediate attention as needed. With a fully integrated health care communication system, clinicians would be able to review a patient's past ED visits, frequency and degree of crisis, and be better informed in making clinical decision-making.

Eliminating the barrier presented by a more fragmented health care system is especially poignant for more vulnerable patients who do not have the capacity to provide a complete and accurate account of their own medical history. Electronic record-keeping negates inefficiencies by creating a more streamlined process of data gathering, eliminating redundancy of data. For clinicians who see patients outside of the hospital network, the current system relies on well-informed patients who have the information in hand or who can recall details of their condition and care. For those who cannot recall, HIT can save valuable time and allow a more timely administration of treatment and care.

HIT can also allow a more efficient continuum of care by eliminating unnecessary follow up. Once again a more streamlined process of data gathering reduces inaccuracies or gaps in a patient's health profile.

Special attention will be taken to address the needs for SMI/SPMI (Serious Mental Illness/ Serious & Persistent Mental Illness) patients who could benefit greatly from integrated care but are not likely to receive this under care of a primary care practitioner. SMI/SPMI patients characteristically do not fit well into traditional primary care practices and are negligent in general health care (late for appointment, repeated no-shows). Many are at high risk for suicide. Suicide figures for New Hampshire are troubling, especially when compared to national figures. Suicide is the second leading cause of death for youth ages 10 to 34, and the eighth leading cause of death overall. Explicit monitoring utilizing all resources needs to be developed.

12e: Challenges and Proposed Solutions:

The Nashua Region IDN is committed to addressing gaps in implementation of a more integrated health care system; gaps include a

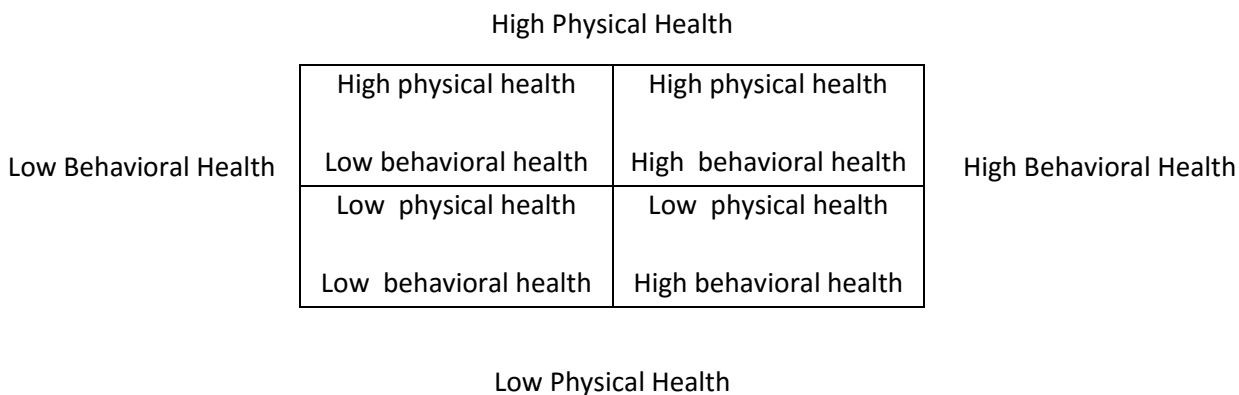
- Shortage of skilled workforce
- Lack of access to care for vulnerable patients (who are homeless, living in poverty, incarcerated, elderly, or otherwise limited in mobility to access care)
- Lack of an effective electronic health record system that hinders information exchange
- Inefficient transition process to facilitate proper care coordination

12f: Implementation Approach and Timing: Supplemental Data Workbook, 12E Tab

The text that follows is a narrative of proposed IDN work. The content will be used to populate the latter tabs of the Workbook once it has been reviewed by members of the Nashua Region IDN.

Several members of the Nashua IDN offered specific programs to enhance integrated care in our community. Below Greater Nashua Community Mental Health (GNMHC) proposes services that are inclusive of a bidirectional model of care.

Any plan for Integrated Care needs to be bidirectional in nature and take into account 4 quadrants of individuals, as their needs may be different. The 4 quadrants are determined by level of physical and behavioral health needs.



The two mixed quadrants of high/low can require different approaches. For example, the high physical health and low behavioral health needs are typically best addressed within the PCP setting while the high BH and low PH are typically best addressed within the CMHC setting. The High/High quadrant is the most challenging and requires significant collaboration and integration.

GNMHC proposes that our IDN defines “High BH” as having a severe mental illness and “eligible” for community level services, per state regulations. We might also chose to simultaneously define “High BH” as those who meet the American Society of Addiction Medicine (ASAM) criteria as requiring inpatient level of SUD treatment.

For improved integration for all High BH:

Increased access to full assessment for eligibility by training nurses/care managers within PH settings on a brief screening for BH. If positive, warm handoff for full evaluation to CMHC. Currently, this can only take place if patient is willing to go to CMHC for evaluation. A possible enhancement through the IDN would be to allow CMHC to do and bill for that assessment within any PH location.

There are many programs proposed that will address the need for improved integrated care throughout the system. The scope of the services include such services as adding Community Health Workers (CHW); training providers on co-occurring disorders; training and supporting providers on issues related to burnout and compassion fatigue; expanding efforts to recruit and retain professionals with the skill sets to treat behavioral health disorders in the primary care setting; and expanding access to all levels of care including substance use disorders, medication assisted treatment, prevention services for youth and adults and peer support. All of these services are described in subsequent pages as they overlap with the community projects. An example of a proposed program is described below:

Partnership for Successful Living; Harbor Homes/Healthy at Home/Keystone Hall
Integrated Care: Community Health Workers and HCH: A Partnership to Promote Primary Care
Community Health Worker

Summary:

The Community Health Worker (CHW) helps increase access to health services for people who have experienced homelessness through outreach, education, and peer support. This position provides a variety of specialized services to special populations. The CHW is expected to have an understanding of mental illness and addiction, being willing and ready to engage with clients who struggle with these issues at all levels.

The CHW is responsible for promoting behavior changes, assisting with linkages to appropriate health care services and assisting individuals with self-management of chronic diseases.

Responsibilities:

- Conducts outreach and prevention education services, targeting individuals in need of a medical home and/or with chronic disease.
- Plan and prepare strategies with community health center and ER (emergency room) on referral process.
- Assists clients in gaining access to and navigating a primary health care medical home and other community based social services (i.e. behavioral health services, housing, legal, etc.)
- Documents each patient served, conducts intake interviews, monitors client progress, maintains logs and statistics.
- Visit clients to develop relationships and promote harm reduction.
- Provides basic advocacy, assessment, planning and casework services.
- Provides culturally and linguistically appropriate services and health education to clients.
- Maintain a professional disposition while working with a multidisciplinary health care team.
- Coordinate transportation for clients to/from appointments, including accompaniment as needed
- Completes accurately, and in a timely manner, all-necessary forms, case recordings and statistical reports, and submits such documentation to his or her supervisor within designated timelines.
- Develop relationships with area social service agencies to build knowledge of the resources available to clients.
- Participates actively in regular supervisory and team meetings, training sessions, conferences, seminars and independent study. Participates in program and operational planning.
- Works toward developing a broad knowledge of casework and carries the volume of work as determined with his or her supervisor.
- Follow-up with clients regarding appointments, care plans, and health goals.
- Other duties may be assigned.
- It is the responsibility of every employee to report any patient safety concern to their immediate supervisor without the fear of reprisal.

Skills:

- Strong organizational skills.
- Strong interpersonal and social skills with demonstrated ability to collaborate with a variety of individuals from a wide range of professional and personal backgrounds.
- Good oral and written communication skills.
- Strong project management abilities.

- Ability to navigate local transportation services (i.e. bus, train, and taxi).

Qualifications:

- High school diploma or GED
- Ability to be trained to perform a variety of tasks
- Bilingual English and Spanish preferred
- Candidates with personal experience of homelessness are strongly encouraged to apply.

Personal Characteristics:

- Ability to convey a strong presence, professional image, and deal confidently with complex situations
- Enthusiasm, interest, and ability to empathize with those who are homeless
- Fosters a respectful sensitivity and non-judgemental attitude towards clients that may suffer with multiple disabilities.
- Treats clients, co-workers, and others with dignity and respect.
- Committed to addressing problems and issues constructively to find mutually acceptable and practical solutions

13. Community-Driven Project #1 (50 points) = C1: Care Transition Teams

13a: Project selection rationale and expected outcomes: Based on the recommendations of the Clinical Governance Committee, the Executive Steering Committee selected *C1: Care Transition Teams* as the first of three Community-Driven Projects, which was validated with the results of the Community Needs Assessment (Surveys). Citing data indicating of the number of patients who visit the ED of multiple local hospitals repeatedly seeking treatment, the Committee named the establishment of care teams as a priority. They recognize care transition teams have been successful in other communities, and look to replicate that success in the Nashua region. Expected outcomes will be measurably fewer visits to the ED, and lower health care costs for Medicaid patients.

Several Nashua Region IDN members recognize the value of integrating community health workers (CHW) into care teams, who can tailor care for patients. CHWs help patients navigate the health care system and work to address their particular social and economic needs and need to be fully integrated into multi-disciplinary care teams to be most effective. They are not effective if working in isolation, making accessibility to providers of great importance to their success.

Harbor Homes is a non-profit community-benefit organization that provides low-income, homeless, and disabled patients with affordable housing, primary and behavioral health care, employment and job training, and supportive services. Harbor Homes provided supporting evidence that successful CHWs come from the communities they serve, and often “speak the same language” as the patients because they have shared experiences. CHWs call on those shared experiences to break the ice and have frank conversations with patients about the status of their health and well-being. CHWs share those conversations with clinicians and providers who with the added information are able to “fine-tune” their approaches to better meet patient needs.

A Nashua Region IDN member shared a 6.12.2012 UNC Gillings School of Global Public Health and UNC School of Medicine publication that cited four communities where CHWs made a difference in the outcome of patient care:

“The Arkansas Community Connector program integrated CHWs into long-term care by finding community members in three disadvantaged Arkansas counties and connecting them to Medicaid home and community-based services. In a three year study involving nearly 2000 participants, those connected with CHWs reported a 23.8 percent average reduction in annual Medicaid spending per participant (Felix et al, 2012)

In Colorado, the Denver Health program is the primary healthcare “safety net” for underserved populations in Denver. They employ CHWs that provide a variety of services including community-based screening and health education, assistance with enrollment in publicly funded health plans, referrals, system navigation, and care management (Whitley et al., 2006). Over a 9 month period patients working with CHWs had an increased number of primary care visits and a decrease in urgent and inpatient care. This resulted in a \$2.38 ROI for every dollar invested with the CHWs (Whitley et al, 2006).

In Kentucky, the Kentucky General Assembly authorized the Kentucky Homeplace Program in 1994. This program currently employs 39 CHWs, called family health care advisors, who provided services to 13,000 clients in 2007 across 58 predominately rural counties. The program received 2 million dollars in funding and in 2007 and was estimated to provide \$15 to \$20 of free or discounted medical services for every dollar invested (Goodwin & Tobler, 2008).

In Maryland, Baltimore CHWs working with diabetes patients on Medicaid achieved a 38% reduction in emergency room visits leading to a 27% drop in Medicaid costs for the patients. It was estimated that each community health worker was responsible for \$80,000 to \$90,000 dollars in savings by alternating weekly home visits and phone contacts (Fedder et al. 2003).

Although these 4 programs vary greatly in size and scope, they are all important in adding to a growing evidence base suggesting CHWs have the potential to provide substantial cost savings in the health care system. Further documentation of the financial impact of these programs can only serve to strengthen the argument for funding such programs. As CHWs continue to receive more recognition and the opportunity for more standardized training, demonstrating their financial impact will take on increased significance.”

Keystone Hall is a Nashua non-profit that provides comprehensive residential and outpatient SUD (substance use disorder) treatment, prevention, and recovery support. Keystone Hall proposes that a Certified Recovery Support Worker (CRSW) also be part of the care team. A CRSW could eventually transition the patient to a Peer Recovery Support Worker (PRSW) for longer-term support beyond the initial phases of the CTI approach. Keystone Hall believes CRSW would be effective to working with justice-involved adults and youth with substance use disorders or significant behavioral health issues.

Healthy at Home is a nonprofit home health care agency that provides a full range of in-home services to help patients remain independent in their own homes for as long as possible. Healthy at Home proposes that home health care workers are part of care transition teams. The worker could be a

psychiatric certified registered nurse RN, or an LPN. The home health care worker can help bridge the gap between physical and behavioral health, particularly in the patient's home environment, outside of the clinical setting in which most other health care providers interact with the patient. This will enable earlier identification of a health crisis, potentially helping to avoid this altogether. It is much less costly for a home health care provider to intervene, than to have the patient seeking treatment in the ED or another institution.

13b: Participating organizations – selection criteria: The initial participating organization is the Partnership for Successful Living and its affiliates: Harbor Homes, Inc., Keystone Hall, and Healthy at Home, Inc. With its long history of responding to the health and welfare needs of the greater Nashua community, the agency desires to be at the forefront of this project. The Partnership for Successful Living is a collaboration of six non-profit organizations providing access to housing, health care, education, employment, and supportive services to help individuals and families achieve sustainable independence.

13c: Participating organizations – list of organizations: Supplemental Data Workbook, 13, 14, and 15D Tabs

13d: Monitoring Plan: As noted earlier in this Project Plan, monitoring is key to ensuring the fidelity of implementation to sustain much of the work of this Project Plan and to improving outcomes. In support of building dedicated resources in support of the expansion of intensive SUD Treatment options, Southern New Hampshire Health, the Nashua Region IDN administrative lead, recently established two new leadership positions:

Associate Vice President of Behavioral Health
Vice President of Development and External Affairs

Lisa K. Madden, a trained social worker and proven leader in behavioral health, was named Associate Vice President of Behavioral Health in July 2015. She is responsible for the implementation of high quality behavioral health services including ACCESS, BHU, PHP, IOP, Foundation Collaborative Care, and Integrated Care in the PCP offices. In addition, a key component of this role is to collaborate with community leaders, as we all work to improve the access and scope of behavioral health services throughout the region.

Dr. Stephanie Wolf-Rosenblum joined the Southern New Hampshire Medical Center medical staff in 1988. She has served in various senior leadership roles, including Medical Director of Foundation Medical Partners, Chief Medical Officer of Southern New Hampshire Medical Center, the BOD of Greater Nashua Mental Health Center, and Chair of the NH Quality Assurance Commission and of the Foundation for Healthy Communities. Since starting this new role as Vice President in November 2015, she has worked tirelessly to advocate for behavioral health resource on a state and local level. Dr. Wolf-Rosenblum has strong relationships with many community leaders and will serve as the Senior Administrative Sponsor for the Nashua Region IDN.

13e: Challenges and proposed solutions: The importance of electronic health records that are integrated across service providers and sites are critical to the overall success of this project. The IDN must invest in enhanced technology and shared record-keeping to ensure care coordination across such a

multidisciplinary team. Operational effectiveness with electronic health records is important for achieving better coordination of care teams serving patients with complex needs.

13f: Implementation Approach and Timing: Supplemental Data Workbook, 13, 14, 15G Tabs

The Nashua IDN has offered the following opportunities for programs to improve the transition of care services in our community. They programs vary in approach to include addressing a patient's spiritual needs to emergency department diversion programs. Please note the summaries below:

The Emmaus Institute, Inc. Care Transitions Teams: Integrated Health Care Spiritual Care Dimension Service Proposal
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A person's values orientation, sense of the transcendent and spiritual/religious practice are recognized to play a significant role in one's health status. The Emmaus Institute, Inc. proposes that a Spiritual Care Dimension be included in the Nashua, NH Region III Integrated Delivery Network service delivery model. To that end we propose the following elements for inclusion.

Index of Well-Being (SIWB) which was designed to measure the effect of spirituality on subjective well-being. It has significant correlations with the Zung Depression Scale, General Well-Being Scale and Spiritual Well-Being Scale. Spirituality relates to hope, a necessary foundation for improvement commitment and motivation. The SIWB contains 12 items: 6 from a self-efficacy domain and 6 from a life scheme domain.

We propose further in addition to an inclusion of this instrument in the comprehensive assessment phase of treatment the following elements in the continuum of care by the treatment teams:

- 1) Training of the IDN clinicians in its utilization as a screening instrument by the Emmaus Institute, Inc.
- 2) Consultation made available to clinicians in the course of the treatment they provide by the Emmaus Institute, Inc.
- 3) Referral to Clinical Pastoral Psychotherapy where appropriate as part of the treatment team.
- 4) The provision of training in behavioral health screening for clergy and congregations through programs provided by the Emmaus Institute, Inc. in collaboration with other members of the Nashua Area Interfaith Council.
- 5) Training for clergy and congregations in SUD recognition and referral by the Emmaus Institute, Inc., perhaps in collaboration with Keystone Hall.

This IDN Spiritual Care Dimension Service component would be staffed by an Emmaus Institute, Inc. full time equivalent, master's level plus, licensed clinician who would provide the training, clinical consultation and Clinical Pastoral Counseling. Administrative and Clinical supervision would be provided a quarter time by the Institute's Licensed Pastoral Psychotherapist. The annual salary range is \$50,000 to \$60,000 plus 13% Benefits for the full time position. The quarter time position is one fourth or 25% of that.

Related usual and customary overhead costs would be charged to the Region III IDN in a negotiated agreement. These would also include training materials.

- Harbor Homes proposes that Community Health Workers (CHW) be a core team member implementing the CTI approach.
- Keystone Hall proposes that a Certified Recovery Support Worker (CRSW) also be part of the care team. A CRSW could eventually transition the patient to a Peer Recovery Support Worker (PRSW) for longer-term support beyond the initial phases of the CTI approach.

All of these above positions require lower rates of pay than other clinical service workers, and in most cases, the patient will find it is easier to relate to a CHW or a CRSW. A CHW and CRSW should earn a living wage of at \$34,000-\$38,000, plus benefits. Clinical supervision/overheard would also be factored into the annual cost, at a reasonable rate.

“Many CHWs come from the communities they serve, and often speak the same language—literally or figuratively—as the patients living there. They call upon that shared experience to build relationships with patients, and in turn use their knowledge of patients’ neighborhoods and cultures to help providers fine-tune their approaches to the patients they serve. In this way, they differ from social workers, nurse case managers, or others tasked with helping people with complex needs.”

Certified Recovery Support Workers are substance use disorder recovery support service providers. Requirements in NH are a GED or HS diploma, plus a training course and hands-on work experience for a minimum number of hours. NH’s information on this not as clear as MA’s, so MA’s can be found as the fifth reference below.

- Healthy at Home proposes that home health care workers are part of the care transition team. The worker could be a psychiatric certified registered nurse RN, or an LPN.

The home health care worker can help bridge the gap between physical and behavioral health, particularly in the patient’s home environment, outside of the clinical setting in which most other health care providers interact with the patient. This will enable earlier identification of a health crisis, potentially helping to avoid this altogether. It is much less costly for a home health care provider to intervene, than the ED or another institution. The salary plus benefit range for the Psychiatric Certified RN is \$80,000-\$94,000; for an LPN, the range is \$40,000 to 45,000. An RN would fall somewhere between the two aforementioned salary/benefit ranges, depending on experience. Reasonable overheard and clinical supervision would be an additional cost.

In all of the above, the importance of Electronic Health Records that are integrated across service providers and sites are critical to the overall success of this initiative. The IDN must invest in enhanced technology and shared record keeping to ensure care coordination across such a multidisciplinary team.

Resources:

<http://www.commonwealthfund.org/publications/newsletters/transforming-care/2015/december/in-focus>
<http://chw.upenn.edu/impact>

http://peersforprogress.org/pfp_blog/community-health-workers-and-cost-savings/
<http://mnchwalliance.org/who-are-chws/roles/>
<https://www.dartmouth-hitchcock.org/stories/article/44782>
<http://careersofsubstance.org/advance-your-career/career-paths/recovery-support-peer-worker>

Healthy at Home (Partnership for successful living)

Care Transitions Teams: Behavioral Health RN Case Manager, Full-Time Benefited

Job Summary: New home health care position specifically to work within the integrated healthcare system to reduce ER visits and hospitalizations of the behavioral health and substance abuse population. Provide medical/ behavioral case management services to include, but not limited to creating and implementing individualized care plans to address the clients behavioral and physical needs, serving as a liaison, coordinates care between the clients, providers, families and community agencies. BHRNCM's admit referrals within 24-48 hours, 7 days a week, provide 24/7 crisis intervention, complete medication reconciliations within 24-48 hours of intake and reports relevant issues to providers. Providers may refer to BHRNCM's to assist in putting systems and resources in place before discharge to prevent re-hospitalization. Establishes referrals to providers and services they need, but currently do not have. Provides supportive counseling to patient, caregivers and family; setting realistic, achievable goals. Advocates for their needs. Provides disease teaching, medication management, medication adherence strategies, monitoring for adverse effects of medication and improvement of symptoms.

BHRNCM to refer to appropriate disciplines within the organization such as:

- Social work for community resources, individual therapy, applying for social assistance, and obtaining safe housing.
- Skilled psych nursing for assessment of behaviors, SI/II, AH/VH, medication adherence, SUD counseling, adverse effects to medication and symptom improvement.
- Skilled nursing for chronic disease, wounds and acute illness assessment and treatment.
- PT and OT for home safety, improvement in ADL's and IADL's, decrease falls, increase safety awareness
- SLP for cognitive and communication deficits.
- Medication and Psychiatric LNA's for daily med adherence through prompting and observing for non-adherence such as pocketing, vital signs, weights, blood sugars, reporting of client self-neglect and home appearance to case manager, personal care, motivation to get up and dressed, food preparation. (Currently not covered by the Medicaid waiver, CFI, but should be expanded to Medicaid behavioral health patients with a self-care deficit, but without a coexisting medical condition. Client should not be excluded for not allowing "hands on" care.)
- FFS workers for transportation to doctors' appointments, housekeeping and errand running.

BHRNCM will be responsible for the intake, oversight and reevaluation of the care plan every 60 days or after ER visit or inpatient stay. BHRNCM supervise disciplines on the case, but skilled nursing visits may be delegated to another skilled RN or LPN when appropriate. They are the "communicators and coordinators" of the patients care.

Reports to: Director of Client Services, Administrator

Qualifications: Current registered nurse licensure in the State of New Hampshire. Bachelor Degree or higher in nursing, psychology, social services, community or public health. Current CPR certification. Two

years' clinical experience in related position, familiarity with CMS clinical OASIS quality measures. ANA board certified in Psychiatric Mental Health or Case Management. If uncertified, eligible and willing to be board certified.

Knowledge and Abilities:

- Excellent oral, written, and reading skills. Understanding verbal and written instructions. Accurate documentation in client records. Ability to exchange ideas verbally or written to a diverse population.
- Ability to maintain excellent communication with providers, client, family, staff and others in the care team.
- Ability to work with continuous quality improvement and keeping up to date on industry evidenced based practice.
- Diverse knowledge in areas of Behavioral Health, Substance Abuse, Chronic health conditions and comorbidity.
- Advocate for the client's welfare.
- Understanding of rules and regulations of CMS Medicare and Medicaid services.
- Understanding and adherence to HIPAA rules and regulations.
- Resourcefulness, creativity, flexibility and integrity. Must be able to work with frequent interruptions and unexpected situations.
- Respect for clients and/or families cultural, religious and ethnic values and differences.
- Ability to work independently within a collaborative team.
- Attention to detail.
- Strong nursing skills. Ability to make meaningful observations and complete thorough assessments, document, and create care plans in collaboration with the patient, family and providers.
- Experience and/or training in motivational and therapeutic communication. Patient and caregiver teaching.
- Training in crisis management, psychological first aid and de-escalation.
- Training in administering and interpreting common psychological and substance abuse scales.
- Ability to organize and prioritize work within the caseload to meet patient/ family/ provider/ payer needs within the appropriate timeline.

Responsibilities:

- Makes a thorough initial assessment of client's needs and condition.
- Utilizes appropriate, validated, reliable screening tools when appropriate.
- Coordinates with client to create care plan, implements care plan with coordination from providers and documents it all thoroughly.
- Completes all CMS OASIS documentation, develops goals and plan of care. Submits authorizations to Wellsense or NHHF.
- Prioritizes treatment and resources based on Maslow's hierarchy of needs, medical and psychiatric conditions.
- Administers medication, treatments, and diagnostic orders from providers.
- Works with client and caregivers to gain an increase level of independence and accountability for their health.
- Works with other agencies in the community to coordinate care and communication.
- Reports significant findings to the appropriate provider.

- Teaches, supervises, and counsels client and family regarding nursing needs and related problems as well as providing information/ education on those needs.
- Prepares and maintains client chart.
- Supervises and evaluates other disciplines within the agency, such as the LNA or FFS worker.
- Oversees delegated nursing care.
- Establishes medication standards and expectations with client. Inventories controlled substances and other medications, when required.
- Receives documentation and phone orders from providers.
- Participates in “on-call” with other BHRNCM’s throughout the region.
- Participates in care planning meetings hosted by other agencies or hosts them when necessary.
- Attends facility case conference and in-services.
- Accepts responsibility for own scope of practice.

Compensation: (estimates)

- **Salary:** 62,500-79,000 a year net (add about 35,000 after calculating taxes, benefits and other expenses)
- **Hourly:** 30 to 38 dollars/hr. (about \$55 hourly reimbursement rate)
- **Fee for service/Per visit rate:** \$150 billable rate based on a 3-4 visits daily (**not ideal due to the immense admin time associated with this population**)

This position would need a new, unique billable code for the Medicaid programs.

Dartmouth-Hitchcock Care Transitions Teams: Behavioral Health RN Case Manager
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Position Title:	Behavioral Health RN Case Manager	Job Code:	400200
Exemption	Exempt	Grade:	N07
Status:			
Department	Various	Function:	RGN
Name:			
Reports To:	Director	Date:	02/04/15

Position Summary: A brief description of the overall primary duties

Identifies opportunities in the medical home to improve the health of our patients. Provides health screening and assesses, plans, and coordinates care for assigned population(s). Functions as a resource to patients and families and actively role models patient and family centered care.

Responsibilities: A listing of the key responsibilities

1. Manages and coordinates clinical and behavioral health care of defined populations with identified behavior health and substance use disorders needs in the outpatient setting. Provides complete psychosocial assessments of patients and families,
2. Identifies and assess behavioral health and SUD patients. Performs a focused nursing assessment to include health and disease management, functional status, cognitive/mental status, nutritional status, available support system, cultural requirements, spiritual needs, identify psycho-social-financial concerns and assess environmental limits and strengths. Identifies patients / families at high risk requiring on-going coordination of care.
3. Facilitates the development of a comprehensive interdisciplinary plan of care, with the patient, family and all members of the medical home team. Implements disease management plan of care. Ensures regular updates and revisions to care plan. Assists patient with development of long and short term goals. Assesses unmet needs, strengths and assets of patients and their families.
4. Serves as the point of contact for patients and families at risk. Facilitates access to care.
5. Facilitates transitions of care from inpatient and outpatient or community setting. Assists families in adapting to difficult and complicated dispositions involving complex/catastrophic care needs, multiple agencies/providers and linkage to resources outside the community
6. Coordinates community resources to address/meet needs of a varied population.
7. Organizes support groups
8. Develops strategies with health care team to advocate for patient needs..
9. Facilitates educational opportunities and risk avoidance, performs pre-provider visit planning to ensure productive, effective patient-provider interactions, and performs post-provider visit wrap-up and between visit contact to ensure patient understanding of the treatment plan, develops patient driven goals and strategies to maximize patient ability to meet health specific goals.
10. Participates in the development of strategies and identifies appropriate measures for the evaluation of outcomes. Determines potential focus for groups of patients using available data and tools.
11. Contributes to the development and maintenance of a care delivery system which is patient/family centered, and promotes effective resource utilization.
12. Assists in collecting and evaluating clinical and financial data/outcomes including patient satisfaction, health and functional status, resource utilization and role effectiveness. Identifies and recommends opportunities for improvement in the system. Leads or participates in quality improvement projects for the practice, especially related to the management of patients with chronic illness. Participates in case conferencing in conjunction with peers and the clinical team. Assists in the development of department annual goals and the identification of outcomes for continuous quality improvement.
13. Performs other duties as required or assigned.

Scope: Dartmouth Hitchcock Medical Home patients.

Minimum Qualifications:

- ✓ Bachelor's degree with 3 years of experience in a community-based practice or health plan or the equivalent required.
- ✓ Excellent assessment, communication, interpersonal, and organizational/time management skills.
- ✓ Demonstrated ability to work well as a member of a team and respond calmly and effectively in a fast paced environment.
- ✓ Excellent verbal and written communication skills.
- ✓ Sound decision making, judgment, time management and negotiating skills.
- ✓ Familiarity with electronic medical records, and computer applications including MS Word and Excel.
- ✓ Must demonstrate passion for care of patients with chronic disease.
- ✓ Sound decision making, judgment, and negotiating skills.
- ✓ Knowledge of methods to educate and counsel patients, assess their readiness for changing health behaviors.

Required Licensure/Certification Skills:

- ✓ Current certification in BLS
- ✓ RN or Social Worker license in the state of NH

Gateways

Care Transitions Teams: Addressing a Statewide Shortage of Psychiatric Resource for Intellectually and/or Developmentally Disabled Individuals

For over 25 years Gateways Community Services (Gateways) has served intellectually and developmentally disabled (IDD) individuals in the greater Nashua area. Everyday Gateways encounters the challenges of a system strapped for adequate psychiatric resource as 23% of its ~650 clients have mental health diagnoses. 55 of these people have an unmet treatment need for medication administration and/or therapy. The results are overutilization of the system (Emergency department, in particular), diminished quality of life for the individual and over utilized community services that in and of themselves can't address the need.

A long-term, stable solution must be found. Towards this end, Gateways offers the following proposal for consideration.

ID/DD Telepsychiatry Center of Excellence

The Need: Nationally, there is a shortage of psychiatrists and NH is no exception. This shortage is disproportionately greater for IDD individuals who have a higher incidence of psychiatric disorders as compared to the general population. And, psychiatrists with no sub-specialty training for this population are reluctant to take them on as clients. Increasingly the use of psychiatric telemedicine for the general population has allowed for expanded access into high need areas (e.g. rural) and for high need individuals (e.g. seniors with less mobility).

The Solution: Ohio has successfully addressed their state's deficit in IDD sub-specialty trained psychiatric resource through a successful telepsychiatry center of excellence (COE) project initiated in 2012. This program manages a COE out of Wright State University that, through telehealth technology, delivers psychiatric services to almost 800 individuals in 54 counties and has dramatically decreased over-utilization of the ED and hospital admissions (**for the first 120 individuals engaged in the program, ED**

visits decreased from 195 to 8 and hospitalizations decreased from 74 to 10). Ohio is willing to share their model's design with us including care protocols, technology design, staffing models and more.

NH's Opportunity: For 5+ years Dartmouth-Hitchcock's (DH) psychiatrist, Dr. McLaren, has provided assessments and developed care plans for dual diagnosed individuals (DD and MH) who are destabilized. Dr. McLaren's IDD sub-specialty experience combined with her department's affiliation with the Center for Telehealth at Dartmouth-Hitchcock present an ideal opportunity to build a NH IDD telepsych COE modeled after Ohio's. 10/07/16

Infrastructure Build: NH's 1115 transformation waiver, with its emphasis on enhancing NH's behavioral health (BH) service delivery via building treatment capacity and integrating BH with primary care, offers an opportunity to fund the development of an IDD telepsychiatry center of excellence that can serve the citizens of NH. Through the transformation waiver's project structure, a COE be developed that initially serves the greater Nashua, and Manchester/Derry communities.

NH's Medicaid Telehealth Initiative: In July 2015, a law was enacted that required NH Medicaid to reimburse for telehealth services. NH has adopted the Medicaid definition of telehealth (vs. Medicare's). NH's DHHS currently has a pilot underway with Dartmouth-Hitchcock in which the delivery of non-primary care specialty services is being delivered NH Medicaid fee for service individuals and being billed as an office visit. In mid-October a presentation will be delivered to the MCO's requesting consideration for their acceptance of claims for telehealth office visits.

Sustainability: Gateways has reached out to NH's two MCO's in advance of DHHS' visit to ascertain their openness to accepting claims with the telehealth modifier. This is critical to ensuring the long-term sustainability of the program.

Status: Gateways is engaged in on-going conversations with DHHS, the Nashua and Manchester/Derry IDNs, Ohio's telepsychiatry team, the Dartmouth-Hitchcock psychiatric team and the MCO's. Mid-October is targeted for the development of a financial model, the last overview piece in vetting the viability of this concept.

Next steps: The following steps are most immediate:

1. Work with other IDNs to scope the statewide need.
2. Connect with the MCO's to ascertain willingness to accept telehealth claims.
3. Determine how, through the DSRIP project structure (core-competence – workforce capacity or statewide – integrated healthcare), infrastructure-build funding may be available.
4. Have DH clinical team meet with the Ohio clinical team and state administrator to exchange programmatic information and ascertain the feasibility of model deployment in NH (cost, etc.)

Greater Nashua Community Mental Health

Care Transitions Teams: Using a Psychiatric Emergency Services (PES) Unit to Treat People in Mental Health Crisis (The Alameda Model)

The claim: treating persons in mental health crisis in a psychiatric emergency services (PES) unit enables over 75% of them to achieve sufficient stability to be discharged to their home or to a community-based program within 24 hours, so that: (1) they are treated in the least restrictive setting; (2) disruption to their lives is minimized, (3) psychiatric boarding in hospital EDs is eliminated, (4) unnecessary psychiatric hospitalizations are prevented.

The structure: The PES unit is “typically a stand-alone program dedicated solely to the treatment of individuals in mental health crisis.” It can be locked, unlocked, or a combination; community-based or in-hospital; normally staffed with psychiatric nurses and other mental health professionals on a 24-hour basis; psychiatrists on-site or readily available. The unit can assess and treat people right away, “with the potential for patients to stabilize quickly.” It operates as an outpatient facility; timeline for treating and discharging patients is 23 hours, 59 minutes.

The process:

From the community - California law (WIC 5150-5155) gives police, as well as designated doctors, clinicians and facilities, the authority to detain, transport, and involuntarily hold an individual in acute mental health crisis for up to 72 hours. A police officer who places an individual under a “5150 hold” contacts an EMS ambulance service and transfers custody of the person to the ambulance crew, who perform a “field screening” of the person, “looking only for medical stability issues”. If the person is deemed medically stable, the person is brought directly to the PES unit. Patients may also “self-present” at the PES unit for care.

From the Emergency Department (ED) - When the ambulance crew find that a person in crisis is medically unstable and needs further evaluation and “medical clearance”, the person is taken to the ED. A “streamlined” medical clearance process, in which *no* specific laboratory tests are required, is in place (developed jointly by the area EDs and the PES unit) to facilitate transfer of these individuals (*and* those who self-present at the ED in mental health crisis) to the PES unit. (Experience has shown that lab tests are time-consuming and seldom identify conditions that preclude safe transfer to the PES unit.) On-site psychiatric consult in the ED *not* necessary, as the attending ED physician consults by phone with a psychiatrist at the PES unit. If the doctors agree that transfer is appropriate, the patient is accepted by the PES unit *without* regard to the person’s psychiatric diagnosis or history or whether the person has medical insurance or has access to a psychiatric hospital bed if hospitalization is ultimately found to be needed.

At the PES unit – On the person’s arrival, a triage nurse conducts an initial evaluation for medical stability and then [if appropriate] sends the patient to a triage psychiatrist, stationed by the ambulance bay, who again assesses and makes “a quick determination if some immediate medicines are needed prior to full evaluation”. Once cleared there, the person goes to “a large waiting-room type area where people can sit in chairs or lie down with a pillow or a blanket”. (There are no individual rooms because this is an outpatient service.) Intensive supportive services are provided over the next several hours, with an emphasis on gaining patient engagement and consent to treatment. Injectable medications are used only in extreme situations. Within 24 hours of a patient’s admission, a decision is made on whether the patient needs hospitalization or can return home or go to a placement less restrictive than an ED.

Outcomes in Alameda County: Persons in mental health crisis in EDs are transferred to the PES unit within (on average) 2 hours of ED admission; less than 25% of the persons admitted to the PES unit are psychiatrically hospitalized; over 75% are able to go home or to a community-based program (e.g. detox, crisis residential housing, or “a board and care arrangement”).

Mobile Crisis/Community Crisis Stabilization

In December of 2016, we anticipate that the State of NH will be releasing an RFP for the establishment of a Mobile Crisis Team within the Nashua Region. The RFPs for the Concord and Manchester Regions have already been granted and provide a framework for what we expect the Nashua RFP will include.

The Nashua Mobile Crisis RFP

We expect the following to be part of the upcoming RFP:

1. Establishment of a phone service with clinical personnel available to respond 24/7. Service will include phone triage, phone support, lethality assessment, crisis stabilization counseling, peer support and case management.
2. Development of a clinical assessment process gathering both demographic data and an assessment of the elements of the crisis being presented with the anticipation that wherever appropriate the remediation of the crisis will be a solution employing the clinical resources of GNMHC in the community as well as the resources of other community organizations.
3. Recruitment of clinical staff including a psychiatrist/APRN, Master's level clinicians, peer support specialists, Bachelor level clinicians, and administrative personnel.
4. Establishing a crisis apartment to house 4 consumers that will be available to obviate the need for hospitalization.

Additional Possibility with IDN

Many consumers presenting in a mental health crisis at local emergency rooms do not need to be in the hospital, but have few options between their home and hospital for getting immediate access to the support they need in a time of crisis. The vision of GNMHC is to create a crisis center where individuals who do not require inpatient psychiatric services can get access to the support needed.

The RFP calls for one level of care; Crisis Apartments - In a crisis apartment, a roster of crisis workers or trained volunteer staff provide 24-hour observation, support, and assistance to the person in crisis who remains in the apartment until stabilized and linked with other supports.

We believe that our region needs a greater continuum of care. We are in the process of working with a facilities planner to see if our vacant 18 bed space could be split into different levels of care. Such that we could house both Crisis Apartments and a Crisis Stabilization Unit (CSU). CSU services are provided to individuals who are in psychiatric crisis whose needs cannot be accommodated safely in residential service settings. If we develop a CSU it would be for voluntary consumers who are in need of a safe, secure environment that is still less restrictive than a hospital. The goal of the CSU is to stabilize the consumer and re-integrate him or her back into the community quickly. The typical length of stay in a CSU is less than five days. Consumers in CSUs receive medication, counseling, referrals, and linkage to ongoing services. Multi-disciplinary teams of mental health professionals staff CSUs, which generally cost two-thirds the amount of a daily inpatient stay.

It would be the goal to work with the two local hospitals and ambulance company to establish a mechanism by which we could receive individuals deemed to be in psychiatric crisis who are medically cleared by an EMT. We could thus divert individuals away from the medical ED who did not have need to go there. We would provide an assessment to determine level of care needed and work with other local behavioral health providers for referral. We would need to work with the hospitals closely such that if a walk-in required medical attention or if the medical status of a pt changed, he/she would have access to that level of care.

Costs:

- 1) Construction – some of which may be covered by RFP
- 2) Staffing – dependent on size, APRN/MD options may need to include telepsych which will have different costs

References:

Wetzel, A. E., Thomas, S., MD, Balan, Y., MD, Hosein, R., MS IV, & Noorbakhsh, A., MSIV. (2015, July 28). *Crisis in the Emergency Department* [PDF]. Sacramento, CA: Sierra Sacramento Valley Medical Society.

Jackson, Y. (2005, April). *A Community-Based Comprehensive Psychiatric Crisis Response Service* [PDF]. Technical Assistance Collaborative, Inc.

14. Community-Driven Project #2 (50 points) = D3: Expansion in Intensive SUD Treatment Options, including partial hospital and residential care

14a: Project selection rationale and expected outcomes: Based on the recommendations of the Clinical Governance Committee, the Executive Steering Committee selected *D3: Expansion in Intensive SUD Treatment Options* as the second of three Community-Driven Projects, which was validated with the results of the Community Needs Assessment (Surveys). The Nashua region is in need of additional treatment options to alleviate the sudden and dramatic rise in the number of residents suffering from SUD. IDN members expect added resources will alleviate gaps in service for adolescents, particularly those who fall outside of the typical SUD tx realm and trauma-informed groups for children/youth with SUDs, and adults with severe SUD or SUD co-occurring with other diseases.

14b: Participating Organizations: Selection Criteria: Initial participating organizations are the Partnership for Successful Living and its affiliates Harbor Homes, Inc., Keystone Hall, and Healthy at Home, Inc., and the Greater Nashua Mental Health Center. With their long history of responding to the health and welfare needs of the greater Nashua community, both agencies desire to be at the forefront of this project. The Partnership for Successful Living is a collaboration of six non-profit organizations providing access to housing, health care, education, employment, and supportive services to help individuals and families achieve sustainable independence. The Greater Nashua Mental Health Center is the only mental health center serving the area, and provides individuals of all ages and families with evidence-based care that focuses on recovery.

Both organizations are committed to working to expand treatment options for intensive SUD patients.

The Peggy and David Gilmour Medical Respite Center is a new service that was noted above in this Project Plan. The Center is just now opening for patients. The Medical Respite Center is housed in the Harbor Homes' existing federally qualified Harbor Care Health and Wellness Center in Nashua. The Medical Respite Center is the state's first and only interim medical program of its kind, providing 24 hour, 7 day preparation and recuperation attention (including behavioral and substance misuse) to bridge the gap and fill the void in the delivery of health care services for our underserved population including our veterans.

Medical respite is a cutting-edge, cost-saving, highly effective way to provide acute and post-acute medical care for homeless persons who are too ill or frail to recover from a physical illness or injury on the streets and/or SUD, but who are not ill enough to be admitted to a hospital. Medical respite programs allow homeless individuals the opportunity to recuperate in a safe environment while

accessing medical care and other supportive services. There are about 70 programs nationwide, the closest in Boston, MA through its Healthcare for the Homeless program.

Medical Respite Services	
Acute and post-Acute Clinical Service Available	Supportive Services Available
Pain Management	Benefit and entitlement acquisition
Ambulation/physical therapy	Case management
Medication and diet monitoring	Housing search and placement assistance
Disease management and prevention via patient education	Care coordination
Ongoing assessment and monitoring	Linkages to behavioral health care services
Wound care and infection control	
Discharge planning	

Typically, patients are discharged from a hospital within a day or two of being treated, with instructions to rest, eat well, and complete a course of medication or other treatment until fully recuperated. If an extended inpatient hospital is not a possible option, which has cost implications, residents who are without housing must attempt to follow instructions while living on the street or in a shelter. Recuperation and recovery on the street is nearly impossible; and in a shelter it is very difficult. Unsanitary conditions cause open wounds to become infected, clean bandages quickly become filthy, washing facilities are generally unavailable, medication requiring refrigeration is compromised, and prescribed diets are not available. As a result, health complications arise and patients are often readmitted to hospitals for complications that would have been avoidable if the patient had a home or safe and clean place for recuperation.

Medical respite programs were established to fill this void in the delivery of health care services, particularly now with the rise in vulnerable patients with complex behavioral health issues. Most patients seen in the medical respite setting are referred by hospitals or other community health care providers. Post-acute medical care is delivered by physicians, physician assistants, nurse practitioners, and nurses who may be onsite 24-hours a day or during set hours. Though the length of stay varies depending on the medical condition, the average length of stay in a medical respite program is 2 weeks.

Keystone Hall proposes to offer additional residential beds, in the form of residential withdrawal management (medical detox), as well as high-intensity and low-intensity residential services. Most of the funding to provide the services is available through Medicaid, private insurances, and NH DHHS BDAS, but funding to physically create the additional beds is not provided. Additionally, medical detoxification services require higher levels of clinical care and supervision than other high-intensity substance use disorder treatment services. The reimbursement rate available through Medicaid and/or NH DHHS BDAS does not fully cover the service's expenses.

Working closely with Harbor Homes' Harbor Care Health and Wellness Center's new medical respite center, the Peggy and David Gilmour Medical Respite Center (MRC), Keystone Hall can offer expanded access to a variety of SUD treatment options. The MRC beds can not only serve as residential modality beds when needed (i.e. medical detox), but also offer those patients with other behavioral or physical health challenges a place to recover while receiving other, less intensive SUD Tx services, such as Partial

Hospitalization, Intensive Outpatient, Outpatient Withdrawal Management services, and recovery support services. IDN funds can be used to bridge the gap between traditional reimbursement methods and the cost to provide medical respite services in this innovative way.

Because MRC are intended to be shorter-term stays, when a patient secures safe, temporary or permanent housing, Healthy at Home can continue to provide in-home supports during the transition period, with staff who receive specialized training in working with behavioral health patients providing personal care, LPN, and RN-level services. Home care services, though well-qualified and capable of providing in-home care for individuals with SUDs, are not offered reimbursement for this through traditional pay methods. The costs to provide these services are equivalent to typical home care visit costs, and are based on the provider's level of skill/ education.

The budget for the MRC requires an annual investment from the community, in addition to the traditional reimbursement methods listed above. There are numerous ways to achieve this, with 70 other MRC programs nationwide demonstrating unique partnerships with hospitals, the VAMCs, and state/federal funds.

Additionally, Keystone Hall and Harbor Homes are working in partnership to purchase and renovate a new facility off Exit 5 in Nashua. The new facility will offer 55 beds of residential treatment services, including a Transitional Living Program that will offer low-intensity residential services. These beds will fill a critical gap in Greater Nashua's SUD residential treatment continuum, and are appropriate for community members who require 90 days to 6 months of residential care to maximize self-sufficiency and avoid relapse. Keystone Hall and Harbor Homes are actively seeking capital/ infrastructure funding for these new beds. The project is estimated to cost approximately \$4 million.

This new facility is an ideal location to serve at-risk adolescents, as it is more centrally located in Nashua than Keystone Hall's 615 Amherst Street facility, very close to Nashua High School South, and on the Nashua Transit bus route. The size of the building and multi-purpose use (commercial and other non-profit tenants) make it more appropriate for serving youth and families. Keystone Hall welcomes the opportunity to work with at-risk youth, either in the schools or through other settings. If SUD Tx is needed, the cost to deliver those services in an outpatient setting is paid for using traditional reimbursement methods. However, prevention services are not paid for by any existing source of funds. Of note, the State of New Hampshire awarded many in-school prevention contracts recently – an ideal scenario is to work with the existing contractors and offer treatment services as needed.

Additional Partial Hospitalization Programs and Intensive Outpatient Programs can be developed and/or expanded to meet the needs of a variety of subpopulations, should data demonstrate such needs exist.

Finally, there is a need for behavioral health options that fall outside of the typical SUD Tx realm: trauma-informed groups for children/youth of parents with SUDs, etc. These can be offered as part of a more comprehensive community-wide solution to our SUD crisis, using IDN funding, and falls under prevention activities.

For the purposes of the IDN application requirements, clinical definitions of IOP, PHP, and Withdrawal Management Services adhere to those within the ASAM. The Transitional Living Program (TLP) is not

based on ASAM, but adheres to NH DHHS BDAS' definition. All residential services must be provided in licensed facilities.

Partial Hospitalization (PH) for adults - in partnership with Harbor Care Health and Wellness Center (Harbor Homes), offered 20 hours a week over a five day period, within our outpatient department at the Harbor Care Health and Wellness Center. This program is for adults with SUDs. Time spent in PH varies, but usually is between 4 and 6 weeks. Services include therapeutic milieu, nursing, psychiatric/medical evaluation and medication management (including detoxification as appropriate), group and individual/family therapy, psychological testing, vocational counseling, rehabilitation recovery counseling, substance abuse evaluation and counseling, and behavioral plans for at least 6 hours per scheduled day. The individual will be evaluated by a board certified/eligible psychiatrist or psychiatric nurse practitioner, and monitored no less than once per week thereafter. Ongoing consultation for medical and psychiatric issues will be available within 8 hours by phone and no more than 48 hours face to face. EBPs used include Cognitive Behavioral Therapy and Motivational Interviewing.

Withdrawal Management for adults – outpatient (Level 1) and residential (Level 3.7) - in partnership with Harbor Care Health and Wellness Center (Harbor Homes), Keystone Hall will develop the capacity to provide 24/7 medically monitored residential detoxification and stabilizations services to adults, as well as outpatient withdrawal management. Through this modality, Keystone Hall will provide evaluation, stabilization (medical and non-medical), and fostering of clients' entry into treatment. Within Harbor Homes' medical respite center, opening November 2016, a number of beds will be available on an as-needed basis for opioid/opiate withdrawal. For outpatient withdrawal management services, Keystone Hall will subcontract with Harbor Homes to provide this service, in conjunction with our Outpatient Department staff who will be co-located within the Harbor Care Clinic. Thus, services, will be provided at both 615 Amherst St and 45 High St. We plan to work closely with the local hospitals to operate this program, developing policies and procedures with their input and guidance. We will use ASAM criteria/guidelines, SAMHSA Tip 45: Detoxification and Substance Abuse Treatment, and other relevant guidelines.

Integrated Medicated Assisted Treatment for adults - in partnership with Harbor Care Health and Wellness Center (Harbor Homes) – is offered to all clients in any of our residential or outpatient programs, and includes access to buprenorphine, methadone, naloxone, and/or naltrexone through a partnership with HCHWC and other area MAT providers. Given the shortage of MAT providers state-wide, there is often a waitlist to obtain buprenorphine. Harbor Homes/Keystone Hall is expanding its capacity to provide this and will utilize a Nurse Care Manager model of care to deliver an Office Based Opioid Treatment program in FY17. Keystone Hall is subcontracting this service to Harbor Care Health and Wellness Center, who has been providing Office Based Opioid Treatment for approximately two years.

14c: Participating organizations – list of organizations: Supplemental Data Workbook 13, 14, 15D Tabs

14d: Monitoring Plan: As noted earlier in this Project Plan, monitoring is key to ensuring the fidelity of implementation to sustain much of the work of this Project Plan and to improving outcomes. In support of building dedicated resources in support of the expansion of intensive SUD Treatment options, Southern New Hampshire Health, the Nashua Region IDN administrative lead, recently established two new leadership positions:

Associate Vice President of Behavioral Health
Vice President of Development and External Affairs

Lisa K. Madden, a trained social worker and proven leader in behavioral health, was named Associate Vice President of Behavioral Health in July 2015. She is responsible for the implementation of high quality behavioral health services including ACCESS, BHU, PHP, IOP, Foundation Collaborative Care, and Integrated Care in the PCP offices. In addition, a key component of this role is to collaborate with community leaders, as we all work to improve the access and scope of behavioral health services throughout the region.

Dr. Stephanie Wolf-Rosenblum joined the Southern New Hampshire Medical Center medical staff in 1988. She has served in various senior leadership roles, including Medical Director of Foundation Medical Partners, Chief Medical Officer of Southern New Hampshire Medical Center, the BOD of Greater Nashua Mental Health Center, and Chair of the NH Quality Assurance Commission and of the Foundation for Healthy Communities. Since starting this new role as Vice President in November 2015, she has worked tirelessly to advocate for behavioral health resource on a state and local level. Dr. Wolf-Rosenblum has strong relationships with many community leaders and will serve as the Senior Administrative Sponsor for the Nashua Region IDN.

14e. Challenges and Proposed Solutions: As noted earlier in this section, if SUD Tx is needed, the cost to deliver those services in an outpatient setting is paid for using traditional reimbursement methods; however, prevention services are not paid for by any existing source of funds. Of note, the State of New Hampshire awarded many in-school prevention contracts recently – an ideal scenario is to work with the existing contractors and offer treatment services as needed.

The Nashua Region IDN is committed to deploying resources to negate barriers to expand intensive SUD treatment options:

- Lack of upfront start-up costs
- Lack of skilled workforce
- Lack of resources to access those who have mobility issues
- Lack of Medicaid reimbursement for indirect time for consultation and collaboration with other agencies

14f: Implementation approach and timing: Supplemental Data Workbook, 13, 14, 15G Tabs

In addition to the programs previously described, the following programs have been proposed by members of the Nashua IDN:

Harbor Homes, Inc., Keystone Hall, Healthy at Home, Inc. and the Partnership for Successful Living Expansion in Intensive SUD Treatment Options

Keystone Hall proposes to offer additional residential beds, in the form of residential withdrawal management (medical detox), as well as high-intensity and low-intensity residential services. Most of

the funding to provide the services is available through Medicaid, private insurances, and NH DHHS BDAS, but no funding to physically create the additional beds is not provided. Additionally, medical detoxification services require higher levels of clinical care and supervision than other high-intensity substance use disorder treatment services. The reimbursement rate available through Medicaid and/or NH DHHS BDAS does not fully cover the service's expenses.

Working closely with Harbor Homes' Harbor Care Health and Wellness Center's new medical respite center, the Peggy and David Gilmour Medical Respite Center (MRC), Keystone Hall can offer expanded access to a variety of SUD treatment options. The MRC beds can not only serve as residential modality beds when needed (i.e. medical detox), but also offer those patients with other behavioral or physical health challenges a place to recover while receiving other, less intensive SUD Tx services, such as Partial Hospitalization, Intensive Outpatient, Outpatient Withdrawal Management services, and recovery support services. IDN funds can be used to bridge the gap between traditional reimbursement methods and the cost to provide medical respite services in this innovative way.

A patient's experience at the MRC is intended to be a shorter-term stay; therefore, when a patient secures safe, temporary or permanent housing, Healthy at Home can continue to provide in-home supports during the transition period. This service will be provided by staff who receive specialized training in working with behavioral health patients providing personal care, LPN, and RN-level services. Home care services, though well-qualified and capable of providing in-home care for individuals with SUDs, are not offered reimbursement for this through traditional payor methods. The cost to provide these services are equivalent to typical home care visit costs, and are based on the provider's level of skill/ education.

The budget for the MRC requires an annual investment from the community, in addition to the traditional reimbursement methods listed above. There are numerous ways to achieve this, with 70 other MRC programs nationwide demonstrating unique partnerships with hospitals, the VAMCs, and state/federal funds.

Additionally, Keystone Hall and Harbor Homes are working in partnership to purchase and renovate a new facility off Exit 5 in Nashua. The new facility will offer 55 beds of residential treatment services, including a Transitional Living Program that offers low-intensity residential services. These beds fill a critical gap in Greater Nashua's SUD residential treatment continuum, and are appropriate for community members that require 90 days to 6 months of residential care to maximize self-sufficiency and avoid relapse. Keystone Hall and Harbor Homes are actively seeking capital/ infrastructure funding for these new beds. The project is estimated to cost approximately \$4 million.

This new facility is an ideal location to serve at-risk adolescents, as it is more centrally located in Nashua than Keystone's 615 Amherst St facility, very close to Nashua High South and on a bus route. The size of the building and multi-purpose use (commercial and other non-profit tenants) make it more appropriate for serving youth and families. Keystone Hall welcomes the opportunity to work with at-risk youth, either in the schools or through other settings. If SUD Tx is needed, the cost to deliver those services in an outpatient setting is paid for using traditional reimbursement methods. However, prevention services are not paid for by any existing source of funds. Of note, the State of NH awarded many in-school prevention contracts recently – an ideal scenario is to work with the existing contractors and offer treatment services as needed.

Additional Partial Hospitalization Programs and Intensive Outpatient Programs can be developed/expanded to meet the needs of a variety of subpopulations, should data demonstrate such needs exist.

Finally, there is a need for behavioral health options that fall outside of the typical SUD Tx realm: trauma-informed groups for children/youth of parents with SUDs, etc. These can be offered as part of a more comprehensive community-wide solution to our SUD crisis, using IDN funding, and falls under prevention activities.

For the purposes of the IDN application requirements, clinical definitions of IOP, PHP, and Withdrawal Management Services adhere to those within the ASAM. The Transitional Living Program (TLP) is not based on ASAM, but adheres to NH DHHS BDAS' definition. All residential services must be provided in licensed facilities.

- **Partial Hospitalization (PH) for adults** - in partnership with Harbor Care Health and Wellness Center (Harbor Homes), offered 20 hours a week over a five day period, within our outpatient department at the Harbor Care Health and Wellness Center. This program is for adults with SUDs. Time spent in PH varies, but usually is between 4 and 6 weeks. Services include therapeutic milieu, nursing, psychiatric/medical evaluation and medication management (including detoxification as appropriate), group and individual/family therapy, psychological testing, vocational counseling, rehabilitation recovery counseling, substance abuse evaluation and counseling, and behavioral plans for at least 6 hours per scheduled day. The individual will be evaluated by a board certified/eligible psychiatrist or psychiatric nurse practitioner, and monitored no less than once per week thereafter. Ongoing consultation for medical and psychiatric issues will be available within 8 hours by phone and no more than 48 hours face to face. EBPs used include Cognitive Behavioral Therapy and Motivational Interviewing.
- **Withdrawal Management for adults – outpatient (Level 1) and residential (Level 3.7)** - in partnership with Harbor Care Health and Wellness Center (Harbor Homes), Keystone Hall will develop the capacity to provide 24/7 medically monitored residential detoxification and stabilizations services to adults, as well as outpatient withdrawal management. Through this modality, Keystone Hall will provide evaluation, stabilization (medical and non-medical), and fostering of clients' entry into treatment. Within Harbor Homes' medical respite center, opening November 2016, a number of beds will be available on an as-needed basis for opioid/opiate withdrawal. For outpatient withdrawal management services, Keystone Hall will subcontract with Harbor Homes to provide this service, in conjunction with our Outpatient Department staff who will be co-located within the Harbor Care Clinic. Thus, services, will be provided at both 615 Amherst St and 45 High St. We plan to work closely with the local hospitals to operate this program, developing policies and procedures with their input and guidance. We will use ASAM criteria/guidelines, SAMHSA Tip 45: Detoxification and Substance Abuse Treatment, and other relevant guidelines.
- **Integrated Medicated Assisted Treatment for adults** - in partnership with Harbor Care Health and Wellness Center (Harbor Homes) – is offered to all clients in any of our residential or outpatient programs, and includes access to buprenorphine, methadone, naloxone, and/or naltrexone through a partnership with HCHWC and other area MAT providers. Given the shortage of MAT providers state-wide, there is often a waitlist to obtain buprenorphine. Harbor Homes/Keystone Hall is expanding its capacity to provide this and will utilize a Nurse Care Manager model of care to deliver an Office Based Opioid Treatment program in FY17. Keystone

Hall is subcontracting this service to Harbor Care Health and Wellness Center, who has been providing Office Based Opioid Treatment for approximately two years.

Greater Nashua Community Mental Health
Expansion in intensive SUD Treatment Options, IOP in Schools and Group outpatient treatment in homeless shelter

1) IOP In Schools

Current options within our region for intensive SUD services primarily serve adults. Many agencies have set up IOPs for adolescents in the past. Ultimately, each has closed due to low utilization. Anecdotally, many cited lack of transportation from school and limited parental engagement as reasons for low utilization. GNMHC proposes that the IDN should create an alternative way to provide this service by partnering with the two local high schools to provide ASAM level 2.1 services within them. From ASAM re: Level 2.1 care - "Intensive Outpatient Services for adolescents and adults, this level of care typically consists of 9 or more hours of service a week or 6 or more hours for adults and adolescents respectively to treat multidimensional instability. Level 2 encompasses services that are capable of meeting the complex needs of people with addiction and co-occurring conditions. It is an organized outpatient service that delivers treatment services during the day, before or after work or school, in the evening, and/or on weekends. A detailed description of the services typically offered in this level of care, the care setting and how to identify what patients would benefit best from these services based on an ASAM dimensional needs assessment, begins on page 198 of The ASAM Criteria: Treatment Criteria for Addictive, Substance-Related, and Co-Occurring Conditions (2013)."

Currently Medicaid pays for this service, but location is limited to office. Thus, using the IDN to implement the program would bring value to the community. It is suggested that the IDN utilize the Adolescent Version of the Matrix Model of Intensive Outpatient Alcohol and Drug Treatment. Many staff at GNMHC are trained in the Matrix model directly by the Matrix Institute and we have a trained trainer on staff. In addition, GNMHC is in the process of implementing the Matrix fidelity tools and becoming a Matrix certified provider.

Costs to implement the project:

- 1) Matrix System Specific to Adolescents which includes Manual, handouts, powerpoints, etc - \$695.00
- 2) FTEs needed
 - a. to deliver IOP – 6 hours/wk/school direct time
 - b. to use ASAM criteria to assess for admission to program – 1 hour/assessment
 - c. to consult/collaborate with school personnel – 1-2 hrs/week

Unanswered questions:

- 1) How many students would we expect to meet criteria for this level of care in our high schools?
- 2) Is there enough need to also implement in middle schools?
- 3) Can this be done during school or immediately following school so there is no transportation issue?

2) **Group outpatient treatment in homeless shelter**

Many individuals with an SUD in our region are homeless. Yet, many struggle to engage in treatment due to cycles of relapse and inability to engage in treatment. Many of this population group are in the pre-contemplative stage and would benefit from motivational treatment and then referral for follow up care. Thus, GNMHC, proposes that the IDN invest in an outpatient level of care SUD group (ASAM Level 1) that uses motivational interviewing as a foundation and include some care management/coordination to referral for other levels of care.

One way this might be achieved is to run a Motivational Group 1 to 1.5 hours 1-2x a week at a local shelter directly after a meal time. For example, the Rescue Mission serves lunch 12-1, offering the group at 1pm, could allow some to easily stay rather than make a return trip to the facility.

The group could be led by a Certified Recovery Coach, LADC, or Masters prepared staff trained in MI and knowledgeable in other resources within the IDN. If Care Coordinators are used in other projects this linkage might also be appropriate.

Costs of the project:

- 1) FTE time
 - a. to prep and run the group 3-4 hrs/wk
 - b. care coordination of referrals post-group - ?depends on other projects
- 2) Facility use fee to the shelter?

Unanswered questions:

- 1) Would the soup kitchen or rescue mission be willing to partner with the IDN?
- 2) What is the level of prevalence/need for this type of service? Assumed to be high, but do we have data specific to our region?

Southern New Hampshire Medical Center
Expansion in intensive SUD Treatment Options SUD Recovery Case Manager

Estimated budget for this position:

SUD Recovery Case Manager Budget

2 Positions: Ideally 1 male/1 female 36 hours/week

Employee Costs \$60,000/yr X 2 FTE	\$120,000
Plus 28% Tax, fringe and overhead	\$33,600
Total cost per year	\$156,000

Position Description:

This position will provide assistance to coordinate community care options for individuals seeking drug addiction/substance misuse treatment programs and resource education

Goal: Facilitate access to treatment programs to reduce delay in recovery

Qualification Requirements:

- LADAC Training
- 2 positions; 1 male/1 female
- Bilingual a plus

Position Tasks:

- Initiate referrals to facilities and follow-up
- Identify and address barriers to treatment
- Identify facilities with openings – daily
- Obtain availability status of Suboxone and Vivitrol prescribing physicians
- Provide education and counseling for hospital inpatients seeking treatment programs
- Facilitate outpatient sessions for those awaiting treatment
- Coordinate access to recovery meetings (NA/AA) and transportation needs
- Act as patient advocate for program admission
- Assist with documentation and insurance authorization process
- Work with insurance companies to determine coverage options
- Facilitate insurance application for those without coverage
- Facilitate family support referrals/intervention/education
- Outreach follow-up calls with patients
- Provide education to providers and care team

Schedule:

- Minimum of 5 days; ideally 7 days
- Hours: 12pm-8pm or 10am-6pm

Concerns:

- Current volume in ED: 800,000
- Space barrier – where will person be located
- Bridging skills: non-billable
- Build into IDN

Southern New Hampshire Medical Center

Expansion in intensive SUD Treatment Options Acute Care Case Manager
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TITLE: Acute Care Case Manager	FLSA STATUS: Non-exempt
DEPARTMENT: Patient and Family Services	

Position Summary:

As a member of the Patient Care Services team, the Acute Care Case Manager evaluates the patient's health status and patient/family/significant other's care capabilities to facilitate the discharge planning process. He/She develops multi-disciplinary, age-specific discharge plans of care based on assessment of patient's needs. He/She provides age-specific and culturally appropriate discharge interventions and communicates and documents in a thorough and timely manner. He/She identifies and utilizes age-specific communication and teaching techniques appropriate to patients and family's developmental level. He/She communicates and documents in a thorough and timely manner. He/She demonstrates leadership behaviors through involvement in area activities and performance improvement efforts. The Acute Care Case Manager is accountable to and works under the direction of the Director of Patient and Family Services.

Principal Duties and Responsibilities

Evaluates the patient's health status and patient/family/significant other's care capabilities to facilitate the discharge planning process.

- Assesses patient holistically prior to and at the time of discharge to fully determine needs for a safe discharge plan.
- Assesses patient and family financial resources
- Assesses patient progress through expected hospital course
- Mobilizes resources to achieve clinical outcomes within desired time frame.

Develops multi-disciplinary, age-specific discharge plans of care based on assessment of patient's needs

- Collaborates with clinical staff in developing and coordinating the Discharge Plan of Care
- Acts as resource to physicians/hospital regarding denial process, and appropriately follows-up with appeals.
- Ensures that patients and families have a choice in agency/facility selection by providing resource lists and documenting patient choice
- Conducts review for appropriate utilization of services from admission through discharge
- Utilizes appropriate criteria and conducts concurrent medical record review to determine medical necessity and appropriate level of care for both federal and managed care insurance.

Provides age-specific and culturally appropriate discharge interventions

- Facilitates interdisciplinary patient-care rounds and/or conferences to review treatment goals, optimize resource utilization, provide family education, and identify post-hospital needs.
- Provides appropriate referral/services to patients based on identified needs.
- Refers cases to social worker where patient and/or family would benefit from counseling required to complete complex discharge plan
- Provides arrangements for follow-up care

Identifies and utilizes age-specific communication and teaching techniques appropriate to patient's and family's developmental level.

- Provides patient and family with information regarding discharge resources
- Involves the patient and family in collaborative decisions regarding the discharge plan
- Assesses and records patient's and family's understanding of discharge plan.
- Makes appropriate education referrals (e.g., Diabetes, Mobility, Skin/Wound and Ostomy, etc.)

Liaisons and conducts utilization reviews in a thorough and timely manner.

- Collaborates effectively with outside agencies to facilitate discharge plan.
- Issues non-coverage letters as appropriate.
- Provides timely review to commercial payers as requested
- Issues Important Message from Medicare within 48 hours of discharge consistently
- Promotes appropriate medical record documentation to meet payer requirements

Demonstrates leadership behaviors through involvement in area activities and performance improvement efforts.

- Maintains ongoing competencies in job related areas such as abuse reporting, guardianships, organ donation, CMS regulations, commercial payer contracts and other department specific mandates.
- Participates in departmental and/or organizational committees
- Participates in quality and safety improvement activities

KNOWLEDGE, SKILLS AND ABILITIES REQUIRED:

- Degree in a healthcare related field
- Three-to-five years of related health care experience
- Case Manager Certification preferred.
- Experience in acute care utilization review and/or discharge planning processes preferred.
- Experience in use of Interqual, Milliman or other Healthcare acute criteria desired.
- Excellent written and verbal communication skills
- Able to achieve the following competencies:
 - Abuse reporting
 - Guardianship
 - Discharge planning/Case Coordination
 - Referral to community resources
 - Utilization review

WORKING CONDITIONS:

- Exposure to chemical disinfectants/sterilants, infectious disease, and latex
- Proper protective attire as designated by OSHA requirements.
- Ability to maintain the physical demands of bending, standing, walking, reaching, pushing and pulling, lifting/carrying up to 10 lbs.
- Ability to hear conversational tones, phone messages, etc.
- Requires close visual acuity to perform such activities as viewing a computer monitor, reading, visual inspection involving small parts or operation of machines, and to determine the accuracy and thoroughness of the work assigned.

Employees at the Medical Center must be able to readily adjust to change and handle a rapid-paced environment and the stresses associated with that, while continuing to provide high quality, efficient service. The above statements are intended to describe the general nature and level of work being performed by people assigned to this classification. They are not to be construed as an exhaustive list of all responsibilities and duties of personnel so classified.

Harbor Homes, Inc., Keystone Hall

Expansion in intensive SUD Treatment Options: Medical Detox Program, Medical Respite Program, Residential Treatment Services, At-Risk Adolescent Programs, Prevention Activities

Medical detox (withdrawal management) Program

Keystone Hall proposes to offer residential withdrawal management (medical detox), as well as high-intensity and low-intensity residential services. Medical detoxification services require higher levels of clinical care and supervision than other high-intensity substance use disorder treatment services.

Medical Respite Program

Working closely with Harbor Homes' Harbor Care Health and Wellness Center's new medical respite center, the Peggy and David Gilmour Medical Respite Center (MRC), Keystone Hall can offer expanded access to a variety of SUD treatment options for the homeless/homeless veteran population. The MRC beds can not only serve as residential modality beds when needed (i.e. medical detox), but also offer those patients with other behavioral or physical health challenges a place to recover while receiving other, less intensive SUD Tx services, such as Partial Hospitalization, Intensive Outpatient, Outpatient Withdrawal Management services, and recovery support services.

The gap in the salary budget for the MRC is approximately \$300,000.

Residential Treatment Services

Additionally, Keystone Hall and Harbor Homes are working in partnership to purchase and renovate a new facility off Exit 5 in Nashua. The new facility will offer 55 beds of residential treatment services, including a Transitional Living Program that offers low-intensity residential services. These beds fill a critical gap in Greater Nashua's SUD residential treatment continuum, and are appropriate for community members that require 90 days to 6 months of residential care to maximize self-sufficiency and avoid relapse.

At-Risk Adolescent Programs

Additionally, this new facility is an ideal location to serve at-risk adolescents, as it is more centrally located in Nashua than Keystone's 615 Amherst St facility, very close to Nashua High South and on a bus

route. Keystone Hall welcomes the opportunity to work with at-risk youth, either in the schools or through other settings.

Prevention Activities

Finally, there is a need for behavioral health options that fall outside of the typical SUD Tx realm: trauma-informed groups for children/youth of parents with SUDs, etc. These can be offered as part of a more comprehensive community-wide solution to our SUD crisis, using IDN funding, and falls under prevention activities.

D3 (f): Harbor Homes, Inc., Keystone Hall

Expansion in intensive SUD Treatment Options: Community Health Workers

- Harbor Homes proposes that Community Health Workers (CHW) be a core team member of any community care transition
- Keystone Hall proposes that a Certified Recovery Support Worker (CRSW) also be part of the care team.

The above positions require lower rates of pay than other clinical service workers, and in most cases, the patient will find it is easier to relate to a CHW or a CRSW. A CHW and CRSW should earn a living wage of at \$28,000-35,000.

“Many CHWs come from the communities they serve, and often speak the same language—literally or figuratively—as the patients living there. They call upon that shared experience to build relationships with patients, and in turn use their knowledge of patients’ neighborhoods and cultures to help providers fine-tune their approaches to the patients they serve. In this way, they differ from social workers, nurse case managers, or others tasked with helping people with complex needs.”

From: <http://www.commonwealthfund.org/publications/newsletters/transforming-care/2015/december/in-focus>

Salary range:

Minimum	65,000
Mid	80,000
Maximum	95,000

Specific example:

Patient with SUD admitted via ER with SUD and chronic kidney disease and financial barriers. Patient has had 6 admissions in past 6 months because non-adherence to proposed plans of care. Patient has been at treated medically though with limited intervention addressing SUD. Psychiatric nurse case manager would provide intervention, resources, support for both patient and family. This skill set harmonizes both medical and psychiatric needs of this patient population. We have identified greater than 10% of DH medical admissions have a co-morbid behavior health diagnosis.

The Youth Council

Student Assistant Counselors

Adolescents in greater Nashua rarely enroll in services for substance misuse on their own; instead, they become connected with care after having been arrested by police, suspended from school or engaged in other high risk behavior. Given their role offering a Juvenile Court Diversion Program for first time offenders, a School Suspension Center for 5th to 8th graders and Student Assistance Program services at Nashua's two high schools, The Youth Council is often the first provider to *identify* substance misuse as a problem and coordinate outpatient treatment and follow-up care with the teen's primary care provider as warranted.

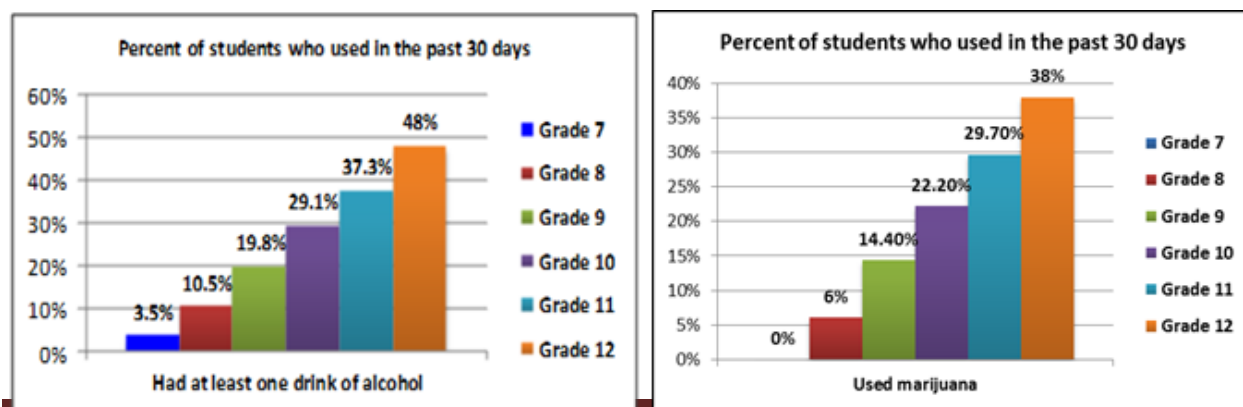
In SFY 2015, The Youth Council provided best-practice, evidenced-based substance misuse services to 145 teens through 60 assessments (33% of youth were female, 67% male), 81 group sessions (19% female, 81% male), and 651 outpatient counseling sessions (47% female, 53% male). Young people served ranged from age 10 to age 19, with 62% between age 15 and 17. Each youth benefited from an average of 24.4 units of service, with an average of ten *new* clients enrolling each month.

As the Nashua IDN builds capacity to integrate care, it is imperative that the safety net be broadened to address the myriad of needs our young people face including those self-medicating with alcohol and other drugs to address mental health needs. For example, through the 2015 Youth Risk Behavior Survey (YRBS) we know that Nashua's high school students are living in riskier environments at higher rates than the state average, and also using alcohol and drugs at higher rates:

- 18.7% saw or heard domestic violence at home (NH 14.8%)
- 31% ever lived with someone with an alcohol or drug problem (NH 30.7%)
- 14.9% have a family member in jail or prison (NH 9.3%)
- 15.3% had a family member currently in the military (NH 15%)
- 13.5% experienced sexual dating violence (NH 11.7%)
- 8.5% experienced physical dating violence (NH 7.8%)

The 2015 YRBS also indicated that 8% of high school students used prescription drugs without a prescription (State 6.8%), 16.8% came to school high on marijuana (State 15.3%), 25.5% currently use marijuana (State 22.2%), 18.1% were offered drugs on school property (State 16.5%), 55.6% did not talk with parents about the dangers of substance misuse (State 50%), 8.8% drove when drinking alcohol (State 6.3%) and 32.8% currently drink alcohol (State 29.9%).

With the School Board's approval of collecting Youth Risk Behavior Survey Data from 7th and 8th grade students in 2015, we can now chart the trajectory of student alcohol and marijuana use (below) as they transition from Middle to High School.



According to the National Institute on Alcohol Abuse and Alcoholism (NIAAA), people who start drinking before the age of 15 are four times more likely to meet the criteria for alcohol dependence at some point in their lives.

While Nashua School District budgeted funds to add one Student Assistance Program counselor for the District, the ideal ratio recommended by the NH Bureau of Drug and Alcohol Services is one counselor for every 1,000 students; hence, four more counselors are needed to meet this standard within Nashua's three middle and two high schools.

Student Assistance Program counselors are in an ideal position to collaborate with school nurses, guidance counselors and primary care, based on the presenting needs of the adolescent and the fact that school-based programming provides a "captive audience". Risks factors leading to SAP referrals include: low self-esteem, anxiety, low-level depressive symptoms, poor problem-solving skills, favorable attitudes toward drugs, substance use among parents, parent/child conflict and low commitment to school. Services can be further integrated by utilizing SAPs to provide Assessment and Brief Intervention for youth screening positive with the region's SBIRT (Screening, Brief Intervention and Referral to Treatment) initiatives within healthcare settings. Through providing assessments, linking with parents and offering individual and group counseling, students will improve their coping skills, increase self-esteem, reduce stress, reconnect with parents and enhance their commitment to school. For youth needing a higher level of intervention, referrals will be made to IDN partners including Greater Nashua Mental Health Center and The Youth Council's outpatient treatment providers.

Edit as you see fit...

Estimated budget – 4 positions @ \$60,000 per position (salary/benefits/overhead/training) = \$240k

That doesn't include any outlying towns. I know that Merrimack would be very interested in adding an SAP back into their school (we used to have that contract when there was Safe and Drug Free Schools) and Souhegan just had to cut theirs due to budget shortfalls, and that was our contract, too.

If we added two more positions to better cover region... add another \$60,000 per position.

I think Hollis/Brookline has someone. Hudson used to... not sure about Milford.

The challenge is around sustainability... not sure how we could get Medicaid to cover it, especially in a high-income town like Amherst.

15. Community-Driven Project #3 (50 points) = E4: Integrated Treatment for Co-Occurring Disorders

15a: Project selection rationale and expected outcomes: Based on the recommendations of the Clinical Governance Committee, the Executive Steering Committee selected *E4: Integrated Treatment for Co-Occurring Disorders* as the third of three Community-Driven Projects, which was validated with the

results of the IDN Community Needs Assessment (Surveys) and the 2014 Greater Nashua Public Health Region Community Health Assessment (CHA) that led to the development of the Community Health Improvement Process (CHIP). In addition, the Nashua Prevention Coalition administered a behavioral survey with results that pointed to the need for increased awareness, education, and prevention strategies for high-risk behaviors among youth.

As evidenced by data published earlier in this Project Plan, prevalence of serious emotional disturbance, serious mental health, and co-occurring mental health and SUD among beneficiary adults and youth, and the prevalence of physical health conditions co-morbid with behavioral health conditions among beneficiary adults and seniors, influenced the selection of this community-driven project. Feedback from the IDN Community Needs Assessment noted specifically the lack of a continuum of care for those with severe mental illness. Too often patients seeking treatment visit a succession of hospital emergency rooms because of a lack of knowledge about intervention and alternative treatment options.

Consequently, to improve the continuum of psychiatric care, the goal is to reduce the lengths of stay in the emergency department and in the inpatient unit, and to facilitate smooth and effective transition to the community for this particularly vulnerable population. Safety and care coordination whether discharged (to be followed up in the community), enrolled in an intensive outpatient program, admitted to an inpatient setting, or transferred to another facility are paramount in prescribing an effective continuum of care for beneficiaries.

Expected outcomes of a patient-centered integration model that moves patients to recovery and beyond illness so they can pursue a personally meaningful life are:

- Reduced substance use
- Improved in psychiatric systems and function
- Decreased hospitalization
- Increased housing stability
- Fewer arrests

15b: Participating Organizations-Selection Criteria: Initial participating organizations are the Partnership for Successful Living and its affiliates Harbor Homes, Inc., Keystone Hall, and Healthy at Home, Inc., and the Greater Nashua Mental Health Center. As noted earlier in this Project Plan, with their long history of responding to the health and welfare needs of the greater Nashua community, both agencies desire to be at the forefront of this project too. The Partnership for Successful Living is a collaboration of six non-profit organizations providing access to housing, health care, education, employment, and supportive services to help individuals and families achieve sustainable independence. The Greater Nashua Mental Health Center is the only mental health center serving the area, and provides individuals of all ages and families with evidence-based care that focuses on recovery.

Both the Partnership for Successful Living and the Greater Nashua Mental Health Center have endorsed two proven, well-developed treatment approaches: *Motivational Interviewing* and *Cognitive Behavioral Therapy*. Both approaches are well documented as evidence-based practices and the integration of these two have been demonstrated as effective with individuals with co-occurring disorders. One of the hallmarks of *Motivational Interviewing* helps to identify an individual's readiness for change and provides the clinician with specific therapeutic interventions to match the individual's stage of change

and promote their progress. The cognitive behavioral approach is designed to address “faulty” thinking that is believed to help maintain the problem, as well as providing specific activities to replace the faulty mental feedback loops and promote positive behaviors that are more consistent with recovery. The Integrated Treatment for Co-occurring Disorders model is endorsed by the Substance Abuse and Mental Health Services Administration (SAMHSA).

15c: Participating organizations – list of organizations: Supplemental Data Workbook, 13, 14, and 15D Tabs

15d Monitoring Plans: Monitoring is key to ensuring the fidelity of implementation and outcomes to maintain and sustain the effectiveness of a patient-centered integration program. In Integrated Treatment programs, the same practitioner or treatment team provides both mental health and substance abuse interventions in an integrated approach. Consumers receive one consistent, integrated message about treatment and recovery.

As noted earlier in this Project Plan, monitoring is key to ensuring the fidelity of implementation to sustain so much of the work of this Project Plan and improve outcomes. In support of building dedicated resources in support of the expansion of intensive SUD Treatment options, Southern New Hampshire Health, the Nashua Region IDN administrative lead, recently established two new leadership positions:

Associate Vice President of Behavioral Health
Vice President of Development and External Affairs

Lisa K. Madden, a trained social worker and proven leader in behavioral health, was named Associate Vice President of Behavioral Health in July 2015. She is responsible for the implementation of high quality behavioral health services including ACCESS, BHU, PHP, IOP, Foundation Collaborative Care, and Integrated Care in the PCP offices. In addition, a key component of this role is to collaborate with community leaders, as we all work to improve the access and scope of behavioral health services throughout the region.

Dr. Stephanie Wolf-Rosenblum joined the Southern New Hampshire Medical Center medical staff in 1988. She has served in various senior leadership roles, including Medical Director of Foundation Medical Partners, Chief Medical Officer of Southern New Hampshire Medical Center, the BOD of Greater Nashua Mental Health Center, and Chair of the NH Quality Assurance Commission and of the Foundation for Healthy Communities. Since starting this new role as Vice President in November 2015, she has worked tirelessly to advocate for behavioral health resource on a state and local level. Dr. Wolf-Rosenblum has strong relationships with many community leaders and will serve as the Senior Administrative Sponsor for the Nashua Region IDN.

According to IDN members, it is important to develop procedures to evaluate the program according to Substance Abuse and Mental Health Services Administration (SAMHSA) guidelines. SAMHSA strongly recommends developing procedures and following through with frequent supervision and evaluation of the performance of integrated treatment specialists. According to SAMHSA, “Identifying professional development so that the specialists understand and consistently apply the evidence-based practices for treating people with co-occurring disorders or identifying further leadership, training and accountability is imperative to reaching goals and sustaining effective treatment.” Leaders need to provide weekly group

supervision to integrated treatment specialists. Group supervision should review beneficiaries involved in the Integrated Treatment program and problem-solve ways to help them better meet their individual goals

15e: Challenges and Proposed Solutions: The Nashua Region IDN is committed to deploying resources to negate barriers to establishing an effective integrated treatment for beneficiaries suffering from complex, co-occurring disorders.

- Lack of upfront start-up costs
- Lack of skilled workforce
- Lack of resources to access those who have mobility issues
- Lack of Medicaid reimbursement for indirect time for consultation and collaboration with other agencies

15f: Implementation Approach and Timing: Supplemental Data Workbook, 13, 14, 15G Tabs

The Nashua IDN offers the following proposals for Integrated Treatment for Co-Occurring Disorders:

Harbor Homes, Inc., Keystone Hall, Healthy at Home, Inc. and the Partnership for Successful Living
Integrated Treatment for Co-Occurring Disorders

The above agencies propose an outpatient integrated behavioral health treatment program for individual with co-occurring disorders that includes three levels of adjunct residential care to complement that outpatient options. The outpatient program will be operated in conjunction with fully integrated physical and oral health care. IDN funding will enable all of the aforementioned services/programs the opportunity to work together in ways that were not previously possible, due to limited reimbursement options.

The residential components include:

- Medical/Behavioral Respite Center – crisis level care offered on-site within the Harbor Care Health and Wellness Center, where all of the behavioral, oral, and primary health care is also provided. Average length of stay is 2 weeks.
- Safe Haven – located within walking distance of the HCHWC in the same building as the Maple Arms Emergency Shelter, this communal living facility is staffed 24/7, and is appropriate for individuals who leave the medical respite center but still require significant residential supports. Healthy at Home staff will continue to offer on-site medical care as needed. Average length of stay is 2 months to 6 months. Most individuals in this program go onto obtain Permanent Supportive Housing in the community, with Functional Support Services often provided.
- Permanent Supportive Housing (PSH) – these are (usually private) apartment units that are provided throughout Greater Nashua, in the client’s choice of apartment. Functional Support Services and other home-based treatment/supports are provided within the resident’s home, as needed. Harbor Homes’ PSH residents’ average length of stay is six years.

The clinical outpatient BH program will offer the following components, as defined in <http://store.samhsa.gov/shin/content//SMA08-4367/BuildingYourProgram-ITC.pdf> :

Multidisciplinary team	Case managers, psychiatrists, nurses, residential staff, employment specialists, and rehabilitation specialists work collaboratively on mental health treatment teams.
Integrated treatment specialist	Integrated treatment specialists work collaboratively with the multidisciplinary treatment team, modeling co-occurring disorders treatment skills and training other staff in evidence-based practice principles and practice.
Stage-wise interventions	All services are consistent with and determined by each consumer's stage of treatment (engagement, persuasion, active treatment, relapse prevention).
Access to comprehensive services	Consumers in the Integrated Treatment program have access to comprehensive services.
Time-unlimited services	Consumers in the Integrated Treatment program are treated on a time-unlimited basis with intensity modified according to each consumer's needs.
Outreach	Integrated treatment specialists demonstrate consistently well-thought-out outreach strategies and connect consumers to community services, whenever appropriate, to keep consumers engaged in the Integrated Treatment program.
Motivational interventions	All interactions with consumers in the Integrated Treatment program are based on motivational interventions.
Substance abuse counseling	Consumers who are in the active treatment or relapse prevention stages receive substance abuse counseling that includes seven specific criteria.
Group treatment for co-occurring disorders	Consumers in the Integrated Treatment program are offered group treatment specifically designed to address both mental health and substance abuse problems.
Family interventions for co-occurring disorders	With consumers' permission, integrated treatment specialists involve consumers' families (or other supporters), provide education about co-occurring disorders, offer coping skills training and support to reduce stress in the family, and promote collaboration with the treatment team.
Alcohol and drug self-help groups	Consumers in the active treatment or relapse prevention stages attend self-help programs in the community.
Pharmacological treatment	Prescribers for consumers in the Integrated Treatment program are trained in the evidence-based model and use five specific strategies (see Fidelity Scale).
Interventions to promote health	Integrated treatment specialists promote health by encouraging consumers with co-occurring disorders to avoid high-risk behaviors and situations that can lead to infectious diseases, find safe housing, and practice proper diet and exercise.
Secondary interventions for nonresponders	The Integrated Treatment program has a protocol to identify consumers who do not respond to basic treatment for co-occurring disorders, to evaluate them, and to link them to appropriate secondary interventions.

Harbor Homes, Inc. and Keystone Hall Integrated Treatment for Co-Occurring Disorders: “Safe Station” Program

The above agencies propose an outpatient integrated behavioral health assessment and treatment program for individual with co-occurring disorders

“Safe Station” Program

Many individuals living with substance misuse are unaware of available services and, when aware, afraid to utilize those services due to stigmatization. We are proposing a “Safe Station” program in collaboration with the Nashua Fire Department to accept “walk-ins” of individuals who are in need of services for integrated behavioral health services. These individuals will be assessed by the EMT’s at the Fire station and, then, once medically cleared, will be referred to Harbor Homes and Keystone Hall for treatment and residential care.

This model has worked quite well in other communities.

The Emmaus Institute Integrated Treatment for Co-Occurring Disorders: Supplement to C1 (a)

Pastoral Care Specialist training program in behavioral health screening and skill development for clergy and qualifying congregational leaders that could address item #4 in the proposal C1 (a): The Emmaus Institute, Inc .Care Transitions Teams: Integrated Health Care Spiritual Care Dimension Service Proposal, which can be found above. This could function as a marketing element for the IDN throughout Region III. It consists in 50 hours of specialized training spread over 16 weeks at 3 hours per week. The costs are \$600 per person for each 8 week program. However, the AAPC Northeast Region would subsidize at up to 50%. The IDN would be responsible for the balance.

The Emmaus Institute would subtract with the AAPC Northeast Regional office training team to provide this service and the Institute would direct and coordinate the program building on its 30 years of relationships in the Nashua Area Interfaith Council as a member. The Institute's current Board of Directors and Advisors include members of the Main Street United Methodist Church, The Church of the Good Shepherd, the First Baptist Church, Christ the King Lutheran Church, the Salvation Army, Temple Beth Abraham and the Church of the Immaculate Conception.

Congregations could be invited to participate which serve census tracts which contain higher levels of Medicaid participants or eligible for participation.

These congregations could participate in preventative and educational programs for various IDN foci such as SUD. This initiative would increase community-based behavioral health service capacity through the education, recruitment and training of a workforce under the State-Wide Project A1.

With a long history of responding to the current health and welfare needs of the greater Nashua community, it should be no surprise that GNMHC desires to be at the forefront of addressing the current opioid / substance misuse crisis in a way that meets the needs of both adolescents (12-17) and adults with co-occurring disorders (mental illness and substance misuse). More specifically, GNMHC proposes to offer Integrated Treatment for Co-occurring Disorders which is based largely on two well developed treatment approaches: Motivational Interviewing and Cognitive Behavioral Therapy interventions. Both of these approaches are well documented as evidence-based practices and the integration of these two have been demonstrated as effective with individuals with co-occurring disorders. One of the hallmarks of this model (Motivational Interviewing) helps to identify an individual's readiness for change and provides the clinician with specific therapeutic interventions to match the individual's stage of change and promote their progress. The cognitive behavioral approach is designed to address "faulty" thinking that is believed to help maintain the problem, as well as providing specific activities to replace the faulty mental feedback loops and promote positive behaviors that are more consistent with recovery.

The Integrated Treatment for Co-occurring Disorders model is endorsed by the Substance Abuse and Mental Health Services Administration (SAMHSA). SAMHSA has published a well thought out "training kit" for this model that is available at no-cost through their website (see <http://store.samhsa.gov/product/Integrated-Treatment-for-Co-Occurring-Disorders-Evidence-Based-Practices-EBP-KIT/SMA08-4367>). The implementation kit needs to be augmented by other resources, including supervision by a seasoned practitioner familiar with this treatment modality. While Medicaid does reimburse for some of the services provided in the model, upfront training costs and the costs for assumed indirect time for consultation and collaboration with others is not currently covered.

We would propose at least 2 teams focused on this approach, one for adolescents (12-17) and one for adults.

Costs to implement the project:

- 1) Training costs for trainer, training materials and staff time
- 2) Supervision cost
- 3) ?non billable costs of consultation and team meetings
- 4) FTE time could be extensive if we desire to implement in both adolescents and adults (but some is reimbursable)....

Unanswered questions:

- 1) I am struggling with finding the age range on ITCD specifically documented. My recollection from when it was IDDT and I was trained is that it was adults only. Yet, one website informally mentioned they were using the model for 12 and up. If it is not evidence based for adolescents, we might consider a secondary proposal using Brief Strategic Family Therapy (BSFT) which has been demonstrated to provide both cost and outcome effective services to those adolescents who have been identified as having either substance misuse problems, mental health concerns, or both (co-occurring).

Appendix A: Project Design and Capacity Building Funds Allocation Tables

**Appendix B: Additional Guidance on Identification and Assessment of Organizations for the
Integrated Healthcare Core Competency Project**

Appendix C: Guidance on Core Competency Project Implementation Approach Table

Appendix D: Guidance on Community Driven Project Implementation Approach Tables